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OCKHAM'S SCALPEL: A RETURN TO A REASONABLENESS STANDARD

ELLEN WERTHEIMER*

I. INTRODUCTION

WILLIAM of Ockham developed a very important scientific principle called Ockham's Razor. Ockham's Razor states that, all other things being equal, when there are two explanations for a phenomenon, the simpler one is more likely to be correct.¹ In the context of this Article, Ockham's Razor may be paraphrased as the proposition that, when a problem in our society requires a solution and there are several solutions from which to choose, the simplest solution may be the most effective. As a fortuitous example, there are several ways of solving the problem of health maintenance organizations (HMOs) that put their own financial concerns ahead of optimum medical treatment for their members. One of the solutions stands out with elegant simplicity: hold HMOs liable in tort when they act unreasonably.

Many persons today belong to HMOs, which are responsible for providing health care to their members.² Under the law as it now exists in many jurisdictions, however, HMOs are not held liable in tort when their decisions are made negligently.³

Tort standards of care and obligations were developed to supply those entities to which they applied with an incentive to act reasonably.⁴ In the

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1. See 8 THE NEW ENCYCLOPEDIA BRITANNICA 867 (15th ed. 1993).

2. See Michele M. Garvin, *Health Maintenance Organizations*, in HEALTH CARE CORPORATE LAW: MANAGED CARE 1-1, 1-6 (Mark A. Hall & William S. Brewbaker III eds., 1996) (discussing health maintenance organization (HMO) model of care). All HMOs tend to work in the same way. See *id.* Each plan member chooses a primary care physician from the HMO list. See *id.* These primary care physicians perform routine services including checkups. See *id.* If the patient develops a problem that requires further medical treatment or testing, the primary care physician refers that patient to one of the specialists on the HMO list. See *id.* at 1-7 ("[T]he primary-care practitioner must generally authorize non-emergency care or treatment before the treatment is provided."). The patient cannot obtain access to specialist treatment unless referred by the primary care physician. See *id.* ("If the member does not seek prior approval, payment for care may be denied."). Hence, primary care physicians are called "gatekeepers," because they control patient access to the other doctors in the HMO. See *id.*

3. For a discussion of the ways in which HMOs escape liability for tort when their decisions are made negligently, see *infra* notes 26-70 and accompanying text.

4. See PETER W. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES 153-54 (1988) (discussing theory that liability and litigation would motivate persons to act in safest manner possible); Robert E. Litan et al., *The U.S.*

absence of tort liability or any alternative form of deterrent, HMOs are free to act in whatever manner they select. Because they have no financial incentive to act reasonably, HMOs are free to allow other concerns, such as making money, to govern their conduct. Such a state of affairs does not serve the interests of the HMO's patients or of society generally.

This Article proposes that the problem of juggernaut HMOs be solved simply by reinstating the obligation that applies to most other members of society: acting reasonably. Failure to act reasonably should be deterred by liability in tort.

II. A PERSONIFICATION OF THE PROBLEM

This Article turns first to a hypothetical situation to highlight the nature of the problem faced by patients, doctors and others when HMOs are not held responsible for their decisions.⁵ The costs of the injuries HMOs cause when they act unreasonably must fall on someone. Failing to hold HMOs liable does not make the costs go away; rather, it imposes those costs on someone else. That someone may be either the patient (if no one is liable) the doctor (if the HMO is not liable) or the hospital that actually provided the treatment. None of these alternatives—all of which are tantamount to liability without fault—is preferable to placing the costs on the party that generated them by its negligent decision.

A. *The Dilemma*

An elderly patient has just undergone an appendectomy. The surgeon feels strongly that the patient should remain in the hospital for five days following the surgery. The HMO which covers the patient allows two days for an appendectomy and denies the doctor's request for a five-day stay. This decision means that the HMO will refuse to pay for the additional three days the doctor feels are necessary for this patient in this situation.

What happens next will vary depending upon whether the physician obeys the HMO or not. In the first scenario below, the physician obeys the directives of the HMO. In the second, he or she does not.

Liability System: Background and Trends, in *LIABILITY: PERSPECTIVES AND POLICY* 3 (Robert E. Litan & Clifford Winston eds., 1988) ("Tort rules will efficiently deter accident-causing behavior if responsibility for the costs of injuries is imposed on those who can avoid or prevent accidents most cheaply."); *see also* TERRENCE F. KIELY, *MODERN TORT LIABILITY: RECOVERY IN THE '90s*, at 288 (1990) ("In essence, a *duty* [in tort law] represents a legally enforceable obligation to conform to a particular standard of conduct.").

5. This situation is purely hypothetical, with no specific treatment protocol, HMO, patient, doctor or hospital in mind. It is (the author hopes) overstated, as hypotheticals tend to be.

1. *Scenario I*

After appealing the HMO decision through the HMO structure, the doctor obeys the HMO and discharges the patient. The patient returns home and dies the next day. If the patient had remained in the hospital, the patient would probably have survived. The patient's estate files suit against the doctor and the HMO.

2. *Scenario II*

The doctor is extremely uncomfortable with discharging the patient and refuses to do so. The patient remains in the hospital for the five days and returns home. The patient undergoes the same crisis as in Scenario I, but because the patient is in the hospital, the patient recovers from it. Recovery is thereafter uneventful.

When the hospital bills the HMO, the HMO refuses to pay for the three days that it did not authorize. The hospital bills the patient. The patient refuses to pay, arguing that he or she is covered by the HMO.

B. *Summary of the Problem*

The issues raised by the above scenarios center around the problem of responsibility. The HMO has made a decision about paying for (or, rather, not paying for) treatment that the physician involved has decided is necessary. The question then becomes one of deciding what the consequences of that decision should be. Assuming that the HMO did not act with due care in denying the physician's request, because as a matter of law due care should allow the physician's medical judgment to govern, should the HMO be liable? By overruling the doctor's medical judgment, the HMO has made a treatment decision of its own, one which turns out to be determinative of the patient's fate. Whether or not the HMO is licensed to practice medicine, it has made a medical decision. Should it be required to stand behind this decision?

Because of the network of immunities and special rules that HMOs have persuaded legislatures and courts to adopt, HMOs often avoid responsibility for their treatment decisions.⁶ This Article argues that HMOs should be responsible for their decisions by being held liable when those decisions are unreasonable. If the HMO controls the decision making about a patient, the HMO should be held responsible for the competence of its exercise of that power.

In Scenario I, the HMO has, by overruling the doctor without seeing the patient, reached what is almost by definition a medically unreasonable decision. The physician, against his or her better judgment, has obeyed the HMO. The HMO decision has had the tragic consequence of causing a death. The HMO has been negligent, and this negligence has caused

6. For a discussion of how HMOs are able to avoid liability in these situations, see *infra* notes 26-70 and accompanying text.

damage. All of the requirements of tort law have been met: (1) the HMO had a relationship as insurer and health care provider to the decedent and thus owed him or her a duty of care; (2) the HMO has been negligent by overruling the physician; and (3) the HMO's negligence has caused injury.

Scenario II is a bit more complex, because the physician has disobeyed the HMO's directions. It is important to remember that the physician, by his or her disobedience, has saved the patient's life. The physician in the first scenario probably felt trapped into obeying the HMO demand, albeit against his or her better judgment. Because the physician acted against his or her better judgment, however, he or she is also a defendant in the resulting lawsuit in Scenario I. If the HMO is immune from suit, the physician will lose, because the physician was negligent in acting against his or her better judgment, no matter what the HMO said. Even though the decision was not in fact the physician's, the courts may treat it as though it had been.

Perhaps to avoid this result, the physician in Scenario II refused to obey the HMO and followed his or her medical judgment. The physician in Scenario I may have acted in obedience to the HMO to avoid the problem that now arises for the physician in Scenario II: who will pay for the additional three days in the hospital? The HMO refuses, the patient refuses and the cost may remain where it is now, with the hospital. Hospitals, however, cannot afford and should not have to absorb such costs.

In Scenario II, however, there is no basis for a tort suit because the patient was not injured by the HMO decision. The patient would have been injured if the doctor obeyed the HMO, but was saved because the doctor did not. This is clearly a better end result for the patient. It should also be the end result that the legal system encourages, because it saved a life. Thus, it *should* be the economically better result for the HMO and the hospital. If it is not, then there is something wrong with the law.

The problem is that the law has developed in a way that may make the death in Scenario I less expensive or equally costly to the HMO in comparison with the result in Scenario II. If the HMO is immune from suit in Scenario I on whatever grounds (maybe because the doctor made the discharge decision, a fictional but often effective argument), then it has no financial interest in exercising due care to prevent the patient's death and no incentive to allow the extra days the next time the issue arises. If the HMO can be forced to pay for the treatment in Scenario II, then the courts have allowed the anomalous result that the HMO is better off when its negligent orders have been obeyed and the patient died, because in Scenario I the HMO pays nothing and in Scenario II it pays for the additional care. If the HMO cannot be held liable in Scenario II (maybe because the doctor in fact disobeyed the HMO strictures), then the HMO is equally well off in both scenarios, paying nothing in either case. Recall, however, that the HMO caused the patient's death in the former scenario. Is it appropriate for the HMO to be better off or, at worst, equally well off

in the two scenarios? The answer, of course, is no. To the extent that the law allows such a result, the law is wrong.⁷

This Article argues that the law is wrong precisely because it removes the incentive effect of tort law. The solution to HMO irresponsibility lies in simplifying the rules. The HMO should be liable in negligence when its actions have been unreasonable and have caused harm. If the HMO had been facing the prospect of a successful lawsuit in Scenario I, it would have had a powerful incentive to allow the physician's medically reasonable decision to govern.

This Article first turns to the question of how the law developed into the senseless result that Scenario I sets forth.⁸ It then turns to the solution, arguing that tort law should be reinstated to do the job of enforcing standards of care for which it was originally intended.⁹

III. HMOs: THE THRIFT INCENTIVE

HMOs are designed to save money. In the halcyon days of the 1960s, everyone believed that there were enough resources to allow all members of our society access to the best—and most complete and expensive—medical treatment.¹⁰ As health care costs escalated, however, the belief that there were enough resources to go around came into question. Eventually, the pendulum swung away from this point of view and an increased emphasis on economizing in the health care arena appeared.¹¹ This emphasis was a subtle one, because no one wanted openly to admit that soci-

7. Allowing the HMO to escape payment in Scenario II may also provide a powerful disincentive for the hospital to provide treatment in the future. If the hospital ends up paying the cost of the additional days, the hospital is more likely to choose to obey the HMO the next time.

8. For a discussion of how the law has developed to allow HMOs to escape liability, see *infra* notes 26-70 and accompanying text.

9. For a discussion of how tort liability can enforce standards of care, see *infra* notes 71-97 and accompanying text.

10. Of course, this has never been the case. Economically disadvantaged members of our society have never had access to the level of medical care available to the wealthy and adequately insured. See Susan L. Goldberg, *A Cure for What Ails? Why the Medical Advocate Is Not the Answer to Problems in the Doctor-Patient Relationship*, 1 WIDENER L. SYMP. J. 325, 341 (1996) (acknowledging fact that "the wealthy generally receive more and better quality health care than the poor"); Colleen M. Grogan, *The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns*, 22 J. HEALTH POL. POL'Y & L. 815, 831 (1997) (describing disparity of care between middle or upper income persons and poor); John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 714 n.29 (1997) ("The movement to managed care is particularly frightening for vulnerable populations, such as the poor and disabled."); Katherine L. Kahn et al., *Health Care for Black and Poor Hospitalized Medicare Patients*, 271 JAMA 1169, 1170 (1994) (finding that quality of hospital care for insured Medicare patients is influenced by patients' race and financial characteristics). The fact that not everyone had access to the best health care, however, did not prevent the contrary belief from existing.

11. See generally Kenneth R. Wing, *The Economic and Policy Environment of Health Care Law*, in HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION 1-1, -18

ety had accepted the idea that some of its members would be deprived of adequate health care in order to cut costs.¹² The emphasis, however, appeared nonetheless.¹³

HMOs were designed and developed, quite simply, to provide health care more cheaply than the other entities that preceded them as service providers had been able to do.¹⁴ How they could do this, while maintain-

to -21 (Mark A. Hall ed., 1993) (discussing consequence of cost containment in health cases). This commentator noted:

While cost containment may be technically achievable in abstract discussion, the political difficulties should not be understated. Beyond the problems of identifying a cost-containment strategy that will actually slow the growth of health spending in measurable amounts of and resolving competing ideological preferences for one approach over another lies an even more formidable barrier to cost containment: Effective cost-containment necessarily will impose an enormous price on some existing group of individuals or institutions.

Id. at 1-20.

12. See BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 297 (1991) (stating that if society chooses to provide equal access to health care regardless of ability to pay, it must either be willing to face limitless expenditures of resources for health care or find nonmarket means of rationing it).

13. See generally Timothy F. Murphy, *Rationing of Care Underscores Need for Oversight*, HARRISBURG PATRIOT & EVENING NEWS, May 19, 1997, at A9 (expressing concern with HMOs rationing care). One commentator noted: "[T]hat HMOs and [managed care organizations] are in the business of rationing care is something providers and patients [know]. It is this underlying philosophy that care should be 'rationed' for the sake of finances that is anathema for all who have sworn to the Hippocratic oath." *Id.* Direct financial incentives to physicians not to expend resources on patient care are one way of rationing care. See generally HEALTH EDUC. & HUMAN SERV. DIV., U.S. GEN. ACCOUNTING OFFICE, *MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA'S EXPANSION PLAN* (1995).

14. Somewhat ironically, HMOs originally evolved in response to the need of the poor for access to medical treatment and not to curtail services at all. See J. Warren Salmon, *The Health Maintenance Organization Strategy*, in *THE CORPORATE TRANSFORMATION OF HEALTH CARE: ISSUES AND DIRECTIONS* 83, 86-87 (J. Warren Salmon ed., 1990) (discussing economic advantages offered by HMO method of health care delivery). In 1932, a national health committee endorsed them as a means of providing affordable health care to a public ravaged by the depression. See *id.*

In 1971, the Nixon administration endorsed health care cost control, which led to the approval of HMOs by the Department of Health, Education and Welfare, and the House Committee on Ways and Means. This culminated in the passage of the Federal Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 714 (codified at 42 U.S.C. § 300e (1994)), for the funding, development, enabling and regulation of any HMO that becomes certified under the act. See Sara Mars, Note, *The Corporate Practice of Medicine: A Call For Action*, HEALTH MATRIX, Winter 1997, at 241, 259 (discussing federal legislation regarding HMOs); Michael A. Dowell, *The Corporate Practice of Medicine Doctrine Must Go*, HEALTHSPAN, Nov. 1994, at 7, 9 (stating that "federal HMO Act incorporated many of the characteristics that the corporate practice of medicine was designed to protect against"); see also 42 U.S.C. § 300e-10 (prohibiting state laws which inhibit existence of HMOs).

ing the same quality, has never been clear to this author.¹⁵ Indeed, the combination of maintaining quality while cutting costs may prove impossible.¹⁶ In fact, although HMOs may provide health care more cheaply, problems have arisen in the context of both the quality and quantity of the health care they provide.¹⁷

How do HMOs provide health care more cheaply? There are two basic methods for reaching such a result.¹⁸ One lies with providing the same

15. See Council on Ethical and Judicial Affairs, American Med. Ass'n, *Ethical Issues in Managed Care*, 273 JAMA 330, 331 (1995) (expressing concern that managed care incentives compromise quality and integrity of patient care). This Article does not, of course, have any particular HMO in mind. On the one hand, there are no doubt many HMOs that do their best to provide full health care treatment to all of their participants. On the other hand, the law has developed in a way that allows those HMOs that put remaining solvent ahead of complete patient care to act on this priority. The power of regulation that tort law provides is only needed for those HMOs that act unreasonably.

16. See Jack Olender, *Doctors Agree Managed Care Cost-Cutting Is Hazardous*, WASH. INFORMER, Sept. 18, 1996, at 12 (discussing effect of cost cutting in medical care). For the first time, the American Medical Association (AMA)

officially acknowledged what patients—especially medical malpractice patients—have long understood: When HMOs and other managed care organizations cut care to save money, the results are dangerous and sometimes deadly. According to an American Medical Association survey released in July, 71% of physicians believed managed care plans negatively affect the quality of medical care. Ninety-two percent believe their clinical independence is impaired. Half of doctors surveyed believe that rationed medical care—the kind of care typically provided by managed care organizations—leads to medical malpractice.

Id.

17. See Mark Holoweiko, *Bypassing Primary-Care Physicians*, MED. ECON., Apr. 14, 1997, at 3 (describing HMOs retreat from gatekeeper models). Many HMOs have come under fire for the rationing of health care, especially in the area of access to specialists. See *id.* The evidence is mounting, however, that HMOs are being pressured to provide better care to their subscribers. For example, Blue Shield of California now allows patients direct access to specialists within the plan for a slightly larger copayment, Health Net allows enrollees to refer themselves to many specialists within the plan at no extra charge, Minnesota's United Health-Care allows enrollees direct access to panel specialists with no difference in copayment and Pacificare of California lets primary care physicians bypass utilization reviewers when sending patients to specialists within their practice groups. See *id.* Although plans eventually approve the vast majority of specialty referrals anyway, these changes reflect a heightened sensitivity to some of the challenges HMOs have faced.

Managed care organizations contend that they do indeed provide less expensive care while maintaining the quality of such care. See Barry R. Furrow, *Incentivizing Medical Practice: What (If Anything) Happens To Professionalism?*, 1 WIDENER L. SYMP. J. 1, 3 (1996) (discussing increased management of healthcare and claims by managed care organizations that they maintain quality while decreasing costs); see also Barbara Starfield et al., *Costs vs Quality in Different Types of Primary Care Settings*, 272 JAMA 1903, 1907 (1994) (describing study that shows general lack of relationship between quality and costs).

18. See Jeffrey M. Liggio, *Preparing the HMO Case, (Medical Negligence) Trial*, TRIAL, May 1, 1997, at 4-5. One commentator stated:

HMOs try to limit costs of providing health care in two ways: by designing and administering a plan that limits benefits, uses strict underwriting

services, but using economies of scale and the like to reduce the costs of the same services.¹⁹ The other, and the primary cause of concern for this Article, lies with providing fewer services.²⁰

There are several means of reducing costs by cutting services.²¹

techniques or eligibility screening, and controls the quality of care, and by aggressively applying direct cost containment measures that reduce service options, shift patient care to less expensive locations, and minimize the frequency of treatment. . . . HMOs also try to control costs by linking physicians' payments with the organization's goals. For example, the HMO may pay doctors through a risk-based or profit-sharing system. If earnings increase as a result of the doctors' or the hospitals' cost-cutting efforts, the doctors and hospitals receive a share of the profits in addition to standard payments.

Id.

19. See Kevin J. Edgan & Rebecca L. Williams, *Vertically Integrated Networks*, in HEALTH CARE CORPORATE LAW: MANAGED CARE, *supra* note 2, at 5-1; -9 (noting that economies of scale pressure participants in health care industry to pursue vertical integration). Edgan and Williams stated: "Certificate of need and other regulations designed to eliminate unnecessary duplication of services, as well as a desire to avoid prohibitively high costs, give providers strong incentives to share technology and equipment through vertical integration." *Id.* They also stated that "[a]lthough all providers are concerned with quality of care, integration offers seamless health care delivery, which tends to promote quality, consistency, and information exchange." *Id.* at 5-11.

20. See Ellyn E. Spragins, *When Your HMO Says No: How to Fight for the Treatment You Need—and Win*, NEWSWEEK, July 28, 1997, at 73 ("[J]ust saying no helps your HMO charge your employer a nice low price—and still turn a profit."). The justification for providing fewer services must be that the problem with the cost of medical care lies with providing too many services. See Wing, *supra* note 11, at 1-15 ("There is a popular perception that rising health care costs can be directly traced to the seemingly insatiable demands of American consumers for dramatic, high-tech, and invasive life-saving procedures. . . . Americans were paying more for their health care in large part because they were receiving more."). No adequate proof of the proposition that health care had become too expensive because of the provision of excessive services seems to exist. See *id.* at 1-17 (stating that influences of increased use of services or rising costs has diminished). One commentator stated that

[a]t least in recent years, it is clear that consumers are not incurring increasing costs because they are seeking medical care more often. Instead, there is a noticeable increase in the number and complexity of the procedures and tests received per treatment encounter Increased use of health services has played an important role in increasing health care costs, but that role has somewhat diminished in recent years relative to other factors and lies primarily in increases in "intensity" and not increases in rates of "utilization."

Id.

21. See Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 20 (1993) (stating that HMOs can cut costs "by encouraging fewer hospital admissions, more outpatient procedures, and fewer referrals to specialists"). In the course of discussing private sector cost containment, a few commentators have pointed out that

[b]ecause the federal government and most states have not adopted a comprehensive strategy for addressing health care costs, and because private business itself obviously cannot exercise regulatory authority, private business has largely relied on competitive approaches to health care cost

These include setting standards for medical practice pursuant to which a physician who orders a particular procedure must justify any deviation from the normally applicable standards set by the HMO. For example, the physician in hypothetical Scenario II sought permission to deviate from the usual length of stay prescribed by the HMO. Another means is professional utilization review, which occurs when physicians or other qualified professionals review a proposal for specific treatment of a particular patient.²² If the HMO had had no specified time limit for appendectomies, the physician in our hypothetical might not have needed to obtain HMO consent to the proposal of a five-day stay.

Clearly, if the HMO objective of economic health either competes with or subsumes the patient's objective of physical health, then either of the two techniques mentioned above could lead to substantial savings. They could also lead to substantial harm if they are unregulated.²³

containment. These approaches [include] self-insurance, utilization review, cost sharing, and contracting with alternative delivery systems See FURROW ET AL., *supra* note 12, at 363.

22. See FURROW ET AL., *supra* note 12, at 365 (providing statistics that support proposition that utilization review reduces number of services used). These commentators noted that

[u]tilization review seems clearly to have reduced inpatient hospital use and inpatient costs experienced by health plans that have used it. One of the best studies found that it reduced admission of groups by 12.3%, inpatient days by 8%, and hospital expenditures by 11.9%. In particular, it reduced patient days by 34% and hospital expenditures by 30% for groups that had previously high admission rates. . . . It is less clear that utilization review reduces total health care costs, since it often moves care from inpatient to outpatient settings. . . . Moreover, utilization review is most effective in the short run and has less effect on long-term cost increases.

Id.

23. One focus of concern has become HMO use of set standards in responding to nonstandard conditions. See *Roukema Calls for End to "Drive-Through" Mastectomies*, Mar. 13, 1997, available in 1997 WL 4430570 (advocating passage of H.R. 135 requiring at least 48 hours of inpatient hospital care after mastectomies). One commentator stated that

HMOs seem to be making a concentrated attack on the health concerns of women First they were trying to discharge new mothers 12 hours after giving birth. Now we will have outpatient drive-through mastectomies. What will come next? I will not settle for third-world standards for health care for women in this country. This is not legitimate cost-saving. This is cold, callous rationing of care.

Id.

In California, the California Nurses Association filed a complaint alleging that an HMO decision to cut emergency care constituted discriminatory rationing. See Eric Brazil, *Halt Kaiser Cuts, Nurses Tell State Gearing Up for Strike, Union Calls HMO's Emergency Rooms Inadequate*, S.F. EXAMINER, Mar. 13, 1997, at A6 (discussing nurses' suit to "beef up" HMO's emergency care and to place it on probation); see also David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 161-62 (1996) (discussing traditional reliance of patient on doctor's choosing treatment based on optimal outcome and not rationing). One commentator pointed out that

[e]ven if there is no actual harm to the patient, there may be serious

The remaining techniques seem fraught with even more peril than those already mentioned. These include specific physician deterrence from referring patients for additional treatment, whether by economic pressure²⁴ or peer pressure.²⁵

harm to the patient-physician relationship. Historically, physicians have assumed a fiduciary role on behalf of their patients, assuring patients that they will act primarily as advocates for the patient's interests. This fiduciary role is a natural result of the condition of the patient and the role of the physician. Patients are especially needy when they are sick, with their health, and indeed their life, often hanging in the balance. At the same time, they are especially dependent on their physicians, who possess not only a virtual monopoly on the expertise to treat illness but also a virtual monopoly on the use of medical therapies. . . . [W]hen physicians are paid more to do less for their patients, patient trust in physicians will naturally be eroded as patients begin to wonder whether tests and treatments are being withheld because they are not medically indicated or because physicians have a financial interest in denying the care.

Id.

24. See Orentlicher, *supra* note 23, at 162 (discussing problems associated with HMO use of financial incentives on physicians to limit care). Economic pressure would include, for example, reducing the physician's share of the leftover HMO premiums in proportion to that physician's referral of patients. See *id.*

HMOs use direct financial incentives in a number of different ways to affect physician behavior. As one commentator noted:

Micro-management encompasses a variety of ways in which the payor "second guesses" a physician's recommendation and a patient's decision. The most common form of micro-management is through various types of utilization review. . . .

The second approach that payors take towards managing care is through panel selection. In a panel selection (and "de-selection") system, the payor "manages" care indirectly by encouraging or requiring its customers to use only particular physicians or facilities. . . .

The third method of managing care is through direct financial incentives. These can take many forms, but the key is structuring the physician's compensation in ways that create incentives to practice economically.

Henry T. Greely, *Direct Financial Incentives In Managed Care: Unanswered Questions*, HEALTH MATRIX, Winter 1996, at 53, 55-56. One commentator noted that the use of these financial incentives can have both negative and positive effects. See Orentlicher, *supra* note 23, at 161-64. Orentlicher noted that

[c]ommentators have sharply criticized the use of financial incentives to limit care. The most troubling aspect is the risk to patient welfare. If physicians have a personal economic interest in limiting the care they provide their patients, they may delay important tests and treatment or omit the tests and treatment entirely. They may schedule patients for return appointments at intervals between appointments that are too long, or they may try to manage their patients' care too long, unduly stretching the limits of their own expertise, before referring the patients to an appropriate specialist. Physicians may also accelerate the date of a patient's discharge from the hospital after surgery, increasing the risk that a complication of the surgery will develop at home where appropriate care may not be available quickly enough.

Id. at 161. Orentlicher further pointed out that

[w]hile the dangers of financial incentives are very real, there are also very important benefits to using these incentives to limit health care costs. There are two primary advantages of financial incentives. First, their use

IV. HMOs AND THE LAW

This Article now turns to a brief look at how the law applicable to HMOs has developed. HMOs have succeeded to a truly startling extent in avoiding the application of tort law to their conduct. Unfortunately, no alternative set of incentives has developed to replace tort law in this context.

A. *The Corporate Practice of Medicine Concept*

The corporate practice of medicine doctrine prohibits corporations from practicing medicine.²⁶ It was established to insure that patients would be treated by doctors and not by corporations.²⁷ This prohibition is

ensures that the persons who ultimately must be responsible for cost containment—physicians—have sufficient incentive to pursue cost containment. Second, financial incentives preserve the ability of physicians to individualize the care they provide their patients.

Id. at 164.

25. See Howard S. Zuckernam, *Principles of Health Care Facility Organization and Management*, in *HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION*, *supra* note 11, at 2-1, -40 (stating that information about each physician's economic performance is sometimes publicized to other medical staff so entire peer community knows who is costing hospital money). Peer pressure would include circulating lists within the HMO of those gatekeeper physicians who do the most referring of patients, thereby costing the HMO, and the other HMO physicians, the most money. See *id.* Studies of physician feedback programs have produced conflicting results. See *id.* In a Vermont study, on the one hand, performance of tonsillectomies was halved after physicians in certain areas were told that their performance of the operation was 13 times greater than in other areas of the state. See *id.* (citing J.E. Wennberg et al., *Changes in Tonsillectomy Rates Associated with Feedback and Review*, 59 *PEDIATRICS* 821 (1977)). On the other hand, a more recent study found no favorable effect from publication of a physician's economic performance. See *id.* (citing Sankey V. Williams & John M. Eisenberg, *A Controlled Trial to Decrease the Unnecessary Use of Diagnostic Tests*, 1 *J. GEN. INTERNAL MED.* 8 (1986)).

26. See Dowell, *supra* note 14, at 7-8 ("Corporate medicine has existed in one form or another since the post-World War I industrial revolution. . . . [T]he creation of state medical licensing requirements and efforts by the American Medical Association led to the corporate practice of medicine doctrine . . ."). The doctrine prohibiting the corporate practice of medicine originated as an ethical restriction on a physician's economic relations, and arose out of the medical profession's struggle for autonomy in the early 1900s. See *id.* The corporate practice prohibition is based on the principle that a corporation lacks the qualifications necessary to obtain a license to practice medicine. See Mars, *supra* note 14, at 242 (discussing origins of corporate practice of medicine doctrine in context of state law); see also Jeffrey F. Chase-Lubitz, Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 *VAND. L. REV.* 445, 448-50 (1987) (discussing corporate practice of medicine prohibition in context of medical profession's struggle for autonomy in early nineteenth century).

27. See Chase-Lubitz, *supra* note 26, at 448 (discussing medical profession's efforts to distinguish physicians from "quacks" and "sectarians"). The ultimate fear was that corporate decision making would replace the medical judgment of the physician. See *id.* Accordingly, the doctrine evolved to protect the public from quackery and possible abuses stemming from the commercial exploitation of the practice of medicine. See *id.* The leaders of the medical profession feared that if physicians were permitted to work for corporations, corporations would ultimately

based upon the premise—adhered to by the medical profession—that patients are individuals requiring the exercise of an individualized treatment process.²⁸ Because corporations are compelled by their nature to a uniformity of approach that is viewed as anathema by the medical profession, corporations are by definition incapable of practicing medicine.²⁹ The

control the doctors' level of income, their methods of treatment and diagnosis and their relationships with patients. *See id.* at 457-58 (describing possible impact of corporate practice on medical profession). In retrospect, this seems somewhat prophetic. *See* Lisa Rediger Hayward, Comment, *Revising Washington's Corporate Practice of Medicine Doctrine*, 71 WASH. L. REV. 403, 405 (1996) (discussing why corporate practice of medicine doctrine should only be retained to prevent lay interference with physician autonomy in medical decisions).

28. *See, e.g.,* Parker v. Board of Dental Exam'rs, 14 P.2d 67, 72 (Cal. 1932) (discussing divided loyalties between dentists and dental corporations); California Ass'n of Dispensing Opticians v. Pearle Vision Ctr., 191 Cal. Rptr. 762, 768-69 (Ct. App. 1983) (discussing legislative prohibitions of lay control over optometrists); Berlin v. Sarah Bush Lincoln Health Ctr., 664 N.E.2d 337, 343-44 (Ill. App. Ct. 1996) (citing concerns regarding lay control and divided physician loyalties as legitimate public policy concerns), *rev'd*, 688 N.E.2d 106 (Ill. 1997); St. Francis Reg'l Med. Ctr. v. Weiss, 869 P.2d 606, 612 (Kan. 1994) (stating that policy reasons for corporate practice of medicine doctrine include "(1) [c]orporate judgment may be substituted for medical judgment, (2) corporations are not subject to standards of ethics, and (3) an independent judgment on the part of the physician is necessary to serve as a patient advocate"); *see also* Patricia Jacobsen, *Prohibition Against Corporate Practice of Medicine: Dinosaur or Dynamic Problem*, in HEALTH LAW HANDBOOK 67, 68, 78-98 (1993) (stating that corporations lack qualifications necessary for license to practice medicine and, therefore, cannot legally hold one).

29. In order to prevent corporate promulgation of poor medical practice and to prevent commercial exploitation, most states have laws that prohibit a corporate entity from directly or indirectly providing medical services. *See* ALA. CODE § 34-24-50 (1995) (defining practice of medicine with no specific exemptions for corporations); ALASKA STAT. § 08.64.380(6) (Michie 1995) (same); ARK. CODE ANN. § 17-95-202(2)(A)-(E) (Michie 1995) (same); *id.* § 17-95-401 (prohibiting persons from practicing medicine without first obtaining valid license); CAL. BUS. & PROF. CODE § 2052 (West 1995) (stating that those who practice, attempt to practice or advertise without certificate are guilty of misdemeanor); *id.* § 2400 (preventing most corporations from having professional rights); COLO. REV. STAT. ANN. § 12-36-106(1)(a)(f) (West 1995) (defining practice of medicine with no corporate exceptions); *id.* § 12-36-129 (imposing class two misdemeanor penalties on any corporation or other entity that violates requirements for practicing medicine); CONN. GEN. STAT. ANN. § 20-9 (West 1995) (prohibiting practice of medicine without license); DEL. CODE ANN. tit. 24, § 1731(b)(5) (1995) (same); GA. CODE ANN. § 43-34-26(a) (1995) (same); *id.* § 43-34-20(3) (defining practice of medicine with no exceptions for corporations); HAW. REV. STAT. § 453-1 (1993) (same); 225 ILL. COMP. STAT. ANN. 60/3 (West 1995 & Supp. 1997) (prohibiting practice of medicine by persons without valid license); IND. CODE ANN. § 25-22.5-1-1.1 (West 1995 & Supp. 1997) (defining practice of medicine with no corporate exceptions); IOWA CODE ANN. § 147.2 (West 1994 & Supp. 1997) (prohibiting unlicensed practice of medicine); *id.* § 148.1 (defining practice of medicine with no corporate exceptions); KAN. STAT. ANN. § 65-2869 (1995) (same); KY. REV. STAT. ANN. § 311.560 (Michie 1995) (same); *id.* § 311.595(11) (stating that license of any practitioner will be revoked if he or she aids, assists or abets unlawful practice of medicine); MICH. COMP. LAWS ANN. § 333.17011(1) (West 1992) (prohibiting unlicensed individuals from practicing medicine); MISS. CODE ANN. § 73-25-1 (1993) (requiring license to practice medicine); *id.* § 73-25-33 (defining practice of

prohibition against the practice of medicine by corporations protects physicians and patients by preventing a third party—the impersonal corporation—from making treatment decisions that both fail to take into account the individualized nature of medical treatment and run the risk of allowing some motive (such as profit) to intervene between patient and care.³⁰ Corporations are likely to be more interested in corporate welfare than in patient welfare.³¹ Physicians (and patients) are more likely to fo-

medicine with no corporate exceptions); MO. ANN. STAT. § 334.010 (West 1996) (prohibiting practice of medicine without license); MONT. CODE ANN. § 37-3-301(1) (1997) (same); NEB. REV. STAT. § 71-1,102 (1996) (defining practice of medicine with no corporate exceptions); NEV. REV. STAT. § 630.020(1)-(4) (1996) (same); N.H. REV. STAT. ANN. § 329:1 (1995) (same); N.J. STAT. ANN. § 2C:21-20(a) (West 1996) (prohibiting practice of medicine without license); *id.* § 45:9-18 (defining practice of medicine with no corporate exceptions); N.M. STAT. ANN. § 61-6-20 (Michie 1995) (prohibiting practice of medicine without license); N.Y. EDUC. LAW § 6522 (McKinney 1996) (restricting practice of medicine to those who are licensed); N.C. GEN. STAT. § 58-67-170(c) (1995) (prohibiting HMOs from practicing medicine); *id.* § 90-18 (prohibiting practice of medicine without license); OHIO REV. CODE ANN. § 4731.41 (Anderson 1997) (prohibiting practice of medicine without state board certificate); OKLA. STAT. ANN. tit. 59, § 492(C) (West 1995 & Supp. 1997) (defining practice of medicine with no corporate exceptions); OR. REV. STAT. § 677.085 (1995) (same); 63 PA. CONS. STAT. ANN. § 422.10 (West 1996) (limiting practice of medicine to licensed medical doctors); R.I. GEN. LAWS § 5-37-12 (1995) (defining unauthorized practice of medicine); S.C. CODE ANN. § 40-47-40 (Law Co-op. 1996) (defining practice of medicine with no corporate exceptions); S.D. CODIFIED LAWS § 36-4-8.1 (Michie 1995) (prohibiting corporate practice of medicine); TENN. CODE ANN. § 63-6-204(a)(1) (1997) (defining practice of medicine); VT. STAT. ANN. tit. 26, § 1314(a) (1995) (describing penalty for practicing medicine without license); VA. CODE ANN. § 54.1-2902 (Michie 1995) (prohibiting practice of medicine without license and allowing no corporate exceptions); WASH. REV. CODE ANN. § 18.71.021 (West 1995) (prohibiting practice of medicine without license); W. VA. CODE § 30-3-13(a) (1996) (prohibiting unlicensed practice of medicine); WYO. STAT. ANN. § 33-26-102(a)(xi) (Michie 1997) (defining practice of medicine without corporate exceptions); *see also* Kerner v. United Med. Serv., 200 N.E. 157, 162-68 (Ill. 1936) (prohibiting corporation from practicing medicine); Nev. Op. Att'y Gen. 40 (1977) (prohibiting any corporation organized under Nevada general corporation statute from engaging in practice of medicine); N.Y. Op. Att'y Gen. 50 (1963) (prohibiting New York corporations from bringing together physicians and patients as against public policy of state).

30. *See* Hayward, *supra* note 27, at 406 (discussing rationale of corporate practice of medicine doctrine and noting that doctrine is means to protect public from possible abuses stemming from commercial exploitation of practice of medicine).

31. *See* Dowell, *supra* note 14, at 7 (noting that some of early fears that led to development of corporate practice of medicine doctrine revolved around loss of sanctity of independent physician-patient relationships and conflicting interests of physicians and profit-oriented corporations). The Supreme Court of South Carolina noted that if corporations were allowed to practice medicine, "professional standards would be practically destroyed, and professions requiring special training would be commercialized, to the public detriment." *Ezell v. Ritholz*, 198 S.E. 419, 424 (S.C. 1938). Over time, these fears became more well defined and evolved into five specific reasons for the prohibition of the practice of medicine by corporations:

- (1) lay persons should not have control over any professional judgment;
- (2) commercial exploitation of medical practice creates a division of physician loyalty between a patient and the employer/contractor, and would

cus on the patient.³² At least this is the theory.

The preceding should highlight the extent to which the existence of HMOs and their concomitant standardized protocols is inconsistent with the corporate practice of medicine doctrine and the premises upon which it is based. HMOs make treatment decisions by setting standards and making it difficult, if not impossible, for doctors to deviate from them. One would think that HMOs and their standard-setting powers would themselves be foreclosed from existence under this doctrine, given that the doctrine developed out of the premise that the only good medical treatment is individual treatment because all patients are unique.³³ As far as the medical profession is concerned, no two appendectomies are exactly alike. As the presenting conditions of patients become more complex, the unshared aspects increase in importance. HMOs, however, are based upon the premise that patients with similar conditions should be treated exactly the same. All appendectomies are alike in the eyes of the HMO.³⁴

destroy the patient/physician relationship; (3) the presence of a corporate entity is incongruous in the workings of a professional regulatory licensing scheme which is based on personal qualification, responsibility and sanction; (4) a corporation is incapable of the relation of personal confidence and trust requisite to the physician/patient relationship; and (5) a corporation may be more concerned about the level of profit than the patient's well-being or quality of care.

Dowell, *supra* note 14, at 8. HMOs exhibit the type of behavior that the corporate practice of medicine doctrine was designed to prevent, including lay control, divided loyalty and commercialism. See 42 U.S.C. § 300e(c) (1994) (proscribing organizational requirements for HMOs).

32. See Dowell, *supra* note 14, at 8 (stating that personal confidence and trust between patients and their physician is crucial in establishing and maintaining physician-patient relationship).

33. Despite the fact that individualized care, which a corporation will not provide, is required, many jurisdictions no longer enforce this doctrine to preclude corporations from making medical decisions. See *id.* at 7 (noting that influence and applicability of the corporate practice of medicine doctrine has diminished in recent years). In fact, in the vast majority of states, the doctrine may as well not exist. See Hayward, *supra* note 27, at 413-14 (discussing how only 5 states were enforcing doctrine, 26 states were either neglecting doctrine or were ambiguous about its application and 19 states were either ignoring doctrine or had repudiated it); see also John Wiorek, *The Corporate Practice of Medicine Doctrine: An Outmoded Theory in Need of Modification*, 8 J. LEGAL MED. 465, 471-84 (1987) (reviewing status of corporate practice of medicine doctrine in each state). Thus, corporate practice of medicine doctrine is considered to be firmly established in only five states: California, Illinois, Iowa, Kansas and Texas. See *id.* at 473. Many states enforce the doctrine sporadically and 19 states either ignore or have repudiated the doctrine. See *id.* at 476-77, 483.

34. See John Protos, *Ten Things Your HMO Won't Tell You*, SMARTMONEY, Mar. 1, 1996 at 134 (discussing proposition that HMOs generally ignore concerns of individual client). According to one commentator:

Number crunchers at actuarial firms collect historical data and perform outcome studies on different procedures and lengths of stay. Then they provide the information to the HMOs to be used as industry standards. So never mind how you're feeling. If you've had a caesarean section, you should leave the hospital within 48 hours. You've had a stroke? You're

The interaction of HMOs and the corporate practice of medicine doctrine has spawned two ironies. The first is that HMOs argue that a number of safeguards exist that protect patients from the uniformity of HMO standards.³⁵ These include the theory of corporate negligence as applied to hospitals,³⁶ the independent obligations of doctors to their patients³⁷ and statutory duties prohibiting fraud and abuse imposed on physicians.³⁸ These arguments are ironic because they all involve obligations that require the entities controlled by HMOs to disobey HMO strictures.³⁹

The second irony is that HMOs use the corporate practice of medicine doctrine, which was developed to protect patients, as a shield against liability.⁴⁰ The doctrine can allow HMOs to escape liability for

typically headed home within three days, even if you can't walk out on your own.

Id.

35. See Mars, *supra* note 14, at 270-74 (stating that managed care proponents, in response to criticism, cite several safeguards that they claim provide better public protection than corporate practice of medicine doctrine). The theories that managed care proponents cite as evidence that the corporate practice of medicine doctrine is not necessary include (1) the independent duty of hospitals to their patients (the corporate negligence liability theory); (2) the independent duty of physicians to their patients; (3) fraud and abuse statutes; and (4) antireferral statutes. See *id.*

36. See *id.* at 271 (stating that hospital "may be held liable for the negligent treatment of patient in its care under corporate negligence theory of liability"). The fear of lay control or division of loyalty among the physician, the hospital and the patient can be minimized by imposing direct corporate liability. See *id.* at 270-74 (discussing how courts have held hospitals liable for failing to ensure that their staffs monitor patients). Presumably, HMOs are not arguing that they should be liable under a similar theory.

37. See *id.* at 272-73 (discussing "physician's independent duty"). If a physician chooses to prioritize a corporation's interest over that of a patient in regard to treatment, the resulting violation of the standard of care could result in liability under a medical malpractice theory. See *id.* (stating that when physician's level of care falls below standard of care, physician may be held liable for malpractice and that physician must balance corporate policies with responsibility to patient).

38. See *id.* at 274 (discussing Medicare-Medicaid fraud and abuse statutes and antireferral statutes). Managed care organizations argue that the commercialization of medicine is unlikely because of the Medicare-Medicaid fraud and abuse statutes and antireferral statutes. See *id.* (noting that antireferral statutes reduce potential risk for commercial abuse because they discourage physicians from establishing clinics or affiliating with other medical facilities to exploit patients for their own profit). Each statute deters divided loyalties and over commercialization by providing for strict penalties and sanctions. See 42 U.S.C. § 1320a-7b(b) (1994) (providing that violation of Medicare-Medicaid fraud and abuse statutes carries civil monetary penalties of up to \$25,000, criminal sanctions of up to five years in prison and loss of provider status); see also 42 U.S.C. § 1395nn(g)(3) (1994) (stating that civil monetary penalties of up to \$15,000 for each service in violation of Medicare-Medicaid fraud and abuse statutes may be imposed).

39. These remedies require that physicians be willing to disobey HMO edicts, and that the failure to do so constitutes malpractice for which the physician becomes liable.

40. See Wiorek, *supra* note 33, at 466-67 (noting that corporate practice of medicine doctrine may be used as shield by insurance companies seeking to avoid

medical malpractice by arguing that they were not making treatment decisions.⁴¹ The irony here is that HMOs do, in fact, make treatment decisions. HMOs prevent doctors from exercising their individual judgment in a given case, but have somehow succeeded in persuading at least some

paying claims); *see also* *Freedman v. Kaiser Found. Health Plan*, 849 P.2d 811, 816-17 (Colo. Ct. App. 1992) (holding that because HMO is statutorily deemed not to be practicing medicine, HMO cannot direct actions of member physicians and, therefore, is not liable for negligence under respondeat superior doctrine); *Jolly v. Michael Reese Health Plan Found.*, 587 N.E.2d 1063, 1067 (Ill. App. Ct. 1992) (holding HMO is statutorily immune from liability for malpractice); *Moshe v. Anchor Org. for Health Maintenance*, 557 N.E.2d 451, 460 (Ill. App. Ct. 1990) (noting that because HMO has state statutory exemption, HMO is not liable under negligence claims); *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58, 60-61 (Mo. 1989) (holding that HMO was not liable for medical negligence because of statutory immunity); *Propst v. Health Maintenance Plan, Inc.*, 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990) (holding that under state statute HMO is not considered to be engaged in the practice of medicine and, thus, can not be liable for malpractice); *Williams v. Good Health Plus, Inc.—HealthAmerica Corp.*, 743 S.W.2d 373, 374-76 (Tex. App. 1987) (holding that HMO was incapable of practicing medicine under state statute and, therefore, could not, as matter of law, be held liable for malpractice).

41. Although most states prohibit the corporate practice of medicine, most states have also legislated that HMOs are not considered to be practicing medicine. *See* ALASKA STAT. § 21.86.260(c) (Michie 1995) (stating that HMOs are not considered to be practicing medicine); ARK. CODE ANN. § 23-76-109(a)(3) (Michie 1995) (same); COLO. REV. STAT. ANN. § 10-16-421(3) (West 1995) (deeming HMOs as not engaged in practice of medicine and exempting HMOs from laws pertaining to practice of medicine); DEL. CODE ANN. tit. 16, § 9112(a) (1995) (exempting HMOs from laws pertaining to the practice of medicine); FLA. STAT. ANN. § 617.2001(2) (West 1995) (allowing nonprofit corporations to engage in practice of medicine); GA. CODE ANN. § 33-21-28(c) (1995) (deeming HMOs as not practicing medicine); IND. CODE ANN. § 25-22.5-1-2(a)(21)(D) to (c) (West 1995) (deeming HMOs as not practicing medicine only if HMOs do not interfere with physicians' decision making and only if shareholders are licensed to practice medicine); KAN. STAT. ANN. § 40-32089(a)(2) (1995) (granting HMOs ability to provide medical care through providers); ME. REV. STAT. ANN. tit. 24-A, § 4222.2 (West 1995) (stating that HMOs should not be deemed to be practicing medicine); MD. CODE ANN. HEALTH—GEN. I. § 19-704 (1995) (allowing HMOs to operate notwithstanding prohibition against corporate practice of medicine); MASS. GEN. LAWS ANN. ch. 176C, § 2 (West 1996) (deeming HMOs as not practicing medicine and, therefore, not subject to laws relating to practice of medicine); MINN. STAT. ANN. § 62D22-3 (West 1996) (stating that HMOs are not considered as practicing medicine); MONT. CODE ANN. § 33-31-111(3) (1997) (deeming HMO as not practicing medicine); N.J. STAT. ANN. § 26:21-25(c) (West 1996) (same); N.M. STAT. ANN. § 59A-46-30(c) (Michie 1995) (same); OHIO REV. CODE ANN. § 1742.01(G)(3)(a) (Anderson 1997) (same); OKLA. STAT. ANN. tit. 63, § 2505 (West 1995) (prohibiting HMOs from engaging in practice of medicine); 40 PA. CONS. STAT. ANN. § 1554(b)(3) (West 1996) (allowing HMOs to furnish health care by employing providers); R.I. GEN. LAWS § 27-41-5(a)(3) (1995) (allowing HMOs to provide health care by contracting with providers); VA. CODE ANN. § 38.2-4319(C) (Michie 1995) (construing HMOs as not engaged in unlawful practice of medicine); W. VA. CODE § 33-25A-24(c) (1996) (considering HMOs not to be engaged in practice of medicine and, therefore, exempt from laws pertaining to practice of medicine); *see also* Mars, *supra* note 14, at 281-300 (listing states that have legislated that HMOs are not considered to be practicing medicine).

courts that their control over the physicians in their employ does not constitute the practice of medicine.⁴²

Ironically, the corporate practice of medicine doctrine, designed to provide patients with a sword against uniform (and, therefore, wrong-headed) treatment, has become a shield that allows HMOs to perform precisely the function that the doctrine was designed to prevent.⁴³ Doctors, not corporations, practice medicine. Therefore, doctors, and not corporations, are liable for negligence. This ignores the reality of medical practice today, in which doctors are often under the complete control of the HMOs and those within the HMOs who, never having seen the patient, are deciding what treatment the patients should receive.⁴⁴ Not only are the HMO personnel deciding on treatment without seeing the patient, they may not even be doctors themselves.⁴⁵ Their goal is corporate, not patient, well-being.

B. ERISA

In an irony comparable to the use of the corporate practice of medicine doctrine as a defense, HMOs have successfully used the Employee Retirement Income Security Act (ERISA)⁴⁶ to protect their power to make medical decisions.⁴⁷ In those cases won by the HMOs, they have

42. See, e.g., *Propst*, 582 N.E.2d at 1143 (finding that HMO was not liable for negligent acts of physicians with whom it contracted because "[HMO does] not practice medicine, [and therefore it] may not be held liable under a complaint which sounds in medical malpractice").

43. See Mars, *supra* note 14, at 260 ("HMO structure embodies characteristics which the corporate practice of medicine doctrine was designed to avoid.").

44. See Jennifer L. D'Isidori, Note, *Stop Gagging Physicians!*, HEALTH MATRIX, Winter 1997, at 187, 194 (discussing HMO control over physicians through gag provision in physicians contracts that "prevent physicians, either explicitly or implicitly, from giving patients information about treatment options that are not covered by their health plans, even if the treatment options are necessary, safe, and effective"); Ellyn E. Spragins, *Beware Your HMO*, NEWSWEEK, Oct. 23, 1995, at 54 (noting that problems of divided loyalties between physicians and HMOs have produced adverse health consequences for HMO patients).

45. See J. Anthony Manger, *Scrap Corporate Practice of Medicine Doctrine*, HEALTHSPAN, May 1994, at 2 (noting that some HMOs are part of investor-owned chains and governing boards of these HMOs consist of lay people who are answerable to stockholders); see also Mars, *supra* note 14, at 260 ("The decision to approve medical procedure or lengths of hospital stays for HMO subscribers is often made by lay persons.").

46. 29 U.S.C. §§ 1001-1461 (1994).

47. See, e.g., *McClellan v. Health Maintenance Org.*, 604 A.2d 1053, 1062-63 (Pa. Super. Ct. 1992) (holding that plaintiff's breach of contract claim was preempted by ERISA); see also *Elsesser v. Hospital of Phila. College of Osteopathic Med.*, 802 F. Supp. 1286, 1290-92 (E.D. Pa. 1992) (ruling that plaintiff's claims against HMO for intentional misrepresentation pertaining to qualifications of plaintiff's physician and breach of contract were preempted by ERISA). Traditionally, HMOs have been shielded from state lawsuits by federal law. See Frank Bass, *Texas Lawmakers Set to Prescribe New Pro-Patient Rules for HMOs*, WALL ST. J., Nov. 27, 1996, at T1 (discussing fact that managed care industry is being battered by

argued that ERISA preempts tort suits against them, because their service is part of the employment benefits of the affected individual.⁴⁸ In the

proconsumer legislation and that state claims were frequently preempted by ERISA).

48. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (holding that tortious breach of contract claim against HMO was preempted by ERISA's exclusive civil enforcement scheme). ERISA is a comprehensive federal statute designed to promote and protect the interests of employees and their beneficiaries in employee benefit plans and was intended to establish pension plan legislation as a solely federal concern. See L. Frank Coan Jr., Note, *You Can't Get There from Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1036-56 (1996) (discussing HMO tort liability and preemptive effect of ERISA on state law). ERISA establishes minimum standards for employee benefit plans and provides for uniform remedies in the enforcement of such plans. See Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 282, 337 (1995) (discussing how ERISA protects and promotes interests of employees and their beneficiaries through employee benefit plans). Because HMOs are frequently part of an employer's benefit plan, HMOs serving as components of employer-provided benefit plans often use ERISA preemption to limit or avoid liability, especially in malpractice litigation. See *id.* (stating that employers often sponsor HMOs through qualified benefit plans); Coan, *supra*, at 1036 (stating that HMOs serving as components of employer-provided benefit plans often use ERISA preemption to limit or avoid liability). Preemption serves as a complete bar to all state claims and provides the HMO with a statutory right of removal to federal court. See *id.* Moreover, preemption can protect HMO defendants from jury trials and the award of punitive damages, even in cases that proceed to federal trial, because ERISA does not allow a jury trial or allow for the recovery of punitive damages. See MARK A. ROTHSTEIN & LANCE LIEBMAN, *EMPLOYMENT LAW: CASES AND MATERIALS* 468 (3d ed. 1994); see also *Pilot Life Insurance*, 481 U.S. at 43-44 (holding that scope of preemption includes both statutory and common law claims); Coan, *supra*, at 1036 ("ERISA does not entitle plaintiffs to a jury trial or allow for the recovery of the extracontractual compensatory or punitive damages."). As one authority argues:

Claims dealing with denials of benefits under an employee benefit plan will likely be preempted by ERISA. Likewise, misrepresentation and breach of contract claims will likely be preempted by ERISA on the basis that they relate to a benefit plan, even though they are not claims dealing directly with the denial of coverage or the failure to pay benefits. In contrast, ERISA may not preempt when the claim is a "run of the mill" state common law negligence claim. HMOs may be able to argue successfully that claims of direct corporate liability are preempted since such claims implicate the administration of the plan by the HMO.

Bearden & Maedgen, *supra*, at 345; see *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 154-55 (10th Cir. 1995) (ruling that ERISA did not preempt state claim that HMO was vicariously liable because state claim did not involve administration of benefits, but that ERISA did preempt loss of consortium claim against HMO alleging negligent or fraudulent administration of employee benefit plan); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir. 1995) (holding that plaintiff's medical negligence claim was not preempted because plaintiff attacked quality of benefits); *Rodriguez v. Pacificare of Tex., Inc.*, 980 F.2d 1014, 1017 (5th Cir. 1993) (ruling plaintiff's state law claims against HMO preempted by ERISA because HMO was health benefits provider); *Santitoro v. Evans*, 935 F. Supp. 733, 737 (E.D.N.C. 1996) (ruling that plaintiff's state law claim was based on vicarious liability was not preempted because claim involved quality of care); *Roessert v. Health Net*, 929 F. Supp. 343, 350 (N.D. Cal. 1996) (stating that court lacks removal jurisdiction when cause of action for liability relates solely to HMO's administrative

opinions in which the HMO loses on the preemption argument, courts have not hesitated to point out the irony in allowing ERISA, a statute designed to protect workers, to protect HMOs at the expense of workers.⁴⁹ As one court stated:

role); *Prihoda v. Shipritz*, 914 F. Supp. 113, 118 (D. Md. 1996) (holding that ERISA did not preempt plaintiff's vicarious liability claims because complaint was concerned with quality of benefits and not administration); *Chaghervand v. CareFirst*, 909 F. Supp. 304, 311 (D. Md. 1995) (ruling that plaintiff's vicarious liability claim was not preempted by ERISA because claim did not involve ERISA objectives); *Dees v. PrimeHealth*, 894 F. Supp. 1549, 1556 (S.D. Ala. 1995) (holding that ERISA preempted state law claim because Alabama statute was connected to HMO's employee welfare benefits); *Jackson v. Roseman*, 878 F. Supp. 820, 824-26 (D. Md. 1995) (holding that medical malpractice claim did not relate to plan administration when plaintiff argued negligent care by provider); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 548 (S.D. Ill. 1994) (stating that negligence claims based on negligent selection and retention are preempted by ERISA because they generally interfere with administration of benefit plan); *Pomeroy v. Johns Hopkins Med. Serv., Inc.*, 868 F. Supp. 110, 113 (D. Md. 1994) (ruling that state law claims against plan administrator were preempted by ERISA); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994) (holding that ERISA did not preempt negligence claim because claim did not relate to plan administration); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994) (holding that ERISA preempted wrongful death, misrepresentation and breach of contract claims because claims arose over how employer benefits were administered); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097, 1101 (E.D. Pa. 1994) (holding that state law claims based on HMO's own negligence in administration or management of benefit plan were preempted by ERISA); *Butler v. Wu*, 853 F. Supp. 125, 129 (D.N.J. 1994) (preempting plaintiff's vicarious liability claim because plaintiff was covered through employer's benefit plan); *Smith v. HMO Great Lakes*, 852 F. Supp. 669, 671-72 (N.D. Ill. 1994) (ruling that ERISA did not necessarily preempt medical malpractice claims when contractual relationship was present); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 972-73 (S.D.N.Y. 1994) (holding that wrongful death claim suit brought under state law was preempted because services were provided through employer benefit plan); *Pickett v. Cigna Healthplan of Tex., Inc.*, 742 F. Supp. 946, 947 (S.D. Tex. 1990) (ruling that medical malpractice claim was not preempted under ERISA because physician rotation system did not relate to administration of plan).

49. See *Scholtens v. Schneider*, 671 N.E.2d 657, 667 (Ill. 1996) ("The purpose of ERISA is to protect employees, not to provide loopholes through which ERISA plans can avoid paying their debts."). Thus, courts are divided over ERISA preemption. Courts seem to agree that ERISA preempts liability based on HMO negligence, but do not agree on whether ERISA preempts vicarious HMO liability. See *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (ruling that ERISA preempted plaintiff's vicarious medical malpractice claim because it "relates to" HMO's administration of plaintiff's benefit plan); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1322 (5th Cir. 1991) (holding that ERISA preempted medical malpractice action brought against administrative entity whose function involved furnishing medical benefits and giving "medical advice").

Courts are undecided on the question of preemption in the vicarious liability context. Compare *Rodriguez*, 980 F.2d at 1017 (holding that ERISA preempts medical malpractice claims based on vicarious liability), *Pomeroy*, 868 F. Supp. at 113-14 (same), *Butler*, 853 F. Supp. at 129 (same), *Nealy*, 844 F. Supp. at 972-73 (same), and *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D.N.J. 1993) (same), with *Burrage*, 59 F.3d at 153-54 (ruling that ERISA does not preempt medical malpractice claims based on vicarious liability), *Roessert*, 929 F. Supp. at 353 (same), *Schachter v. Pacificare of Okla., Inc.*, 923 F. Supp. 1448, 1451-52 (N.D. Okla. 1995) (same),

Prihoda, 914 F. Supp. at 118 (same), *Chaghervand*, 909 F. Supp. at 311 (same), *Jackson*, 878 F. Supp. at 826 (same), *Haas*, 875 F. Supp. at 548 (same); *Dearmas*, 865 F. Supp. at 818 (same); *Kearney*, 859 F. Supp. at 186-88 (same), *Burke v. Smithkline Bio-Science Lab.*, 858 F. Supp. 1181, 1184 (M.D. Fla. 1994) (same), and *HMO Great Lakes*, 852 F. Supp. at 671-72 (same).

It also appears that suits against HMOs dealing with the denial of benefits are more likely to be preempted by ERISA, while common law causes of action for medical malpractice are less likely to be so. See Bearden & Maedgen, *supra* note 48, at 337-45 (discussing evolving trend in which claims against HMOs for failure to provide benefits will likely be preempted by ERISA, but common law medical malpractice actions involving HMOs will not be preempted). One problem may lie in deciding whether a particular cause of action is one for malpractice or the denial of benefits; a denial of benefits may be malpractice. In *Corcoran*, a pregnant mother was denied disability benefits and hospitalization under an employee benefit plan even though she was undergoing high-risk pregnancy. *Corcoran*, 965 F.2d at 1323-24. After the fetus died, the parents brought suit against the utilization review organization. See *id.* at 1324. The plaintiffs claimed that the refusal of benefits was an erroneous medical decision. See *id.* The defendant argued that the decision was made by the benefit plan as to what benefits were available under the plan. See *id.* at 1325 (arguing that relationship between defendant and plaintiff "came into existence solely as a result of an ERISA plan and was defined entirely by the plan," and asserting that plaintiff's state law claims, therefore, were preempted). The court held that the cause of action was preempted by ERISA even though the defendant did make medical decisions because "it [did] so in the context of making a determination about the availability of benefits of the plan." *Id.* at 1331.

Similarly, in another case, the plaintiffs, who had sought benefits under an employee benefit plan, argued that the failure of the HMO to pay their claim constituted a breach of the duty of good faith and fair dealing under Texas common law. See *McManus v. Travelers Health Network*, 742 F. Supp. 377, 379 (W.D. Tex. 1990). The plaintiffs further argued that their claims were based on law concerning the regulation of insurance, thus falling outside the preemptive scope of ERISA. See *id.* The court held that the claim was not specifically directed at the insurance industry as a whole and, therefore, was preempted by ERISA. See *id.* at 380-82 (finding that plaintiff's claim was encompassed by savings clause of ERISA).

Other courts, however, have not allowed ERISA to preempt certain state law claims. In *Pickett*, the plaintiff sued three physicians for negligently failing to diagnose her cancer. *Pickett*, 742 F. Supp. at 947. The HMO argued for removal to federal court, claiming that the plaintiff was challenging administration of the plan. See *id.* The federal court remanded the case to the state level because the plaintiff's claim was a common law medical malpractice case and not one of claims administration. See *id.* But see *Ricci*, 840 F. Supp. at 318 (holding that ERISA preempted state law claim of vicarious liability because alleged malpractice ultimately depended on relationship between physician and administrative plan under which physician functioned).

Courts concluding that ERISA preempts state medical malpractice claims have done so by strictly adhering to a line of Supreme Court cases that interpret ERISA expansively. See Coan, *supra* note 48, at 1025 (discussing Supreme Court precedent that guided lower court in concluding that ERISA preempts state medical malpractice claims). In *Pilot Life Insurance*, the Supreme Court addressed the preemption of state common law claims for the first time. *Pilot Life Insurance*, 481 U.S. at 1048 (noting that Supreme Court had never decided whether ERISA preempts state common law claims). The Court noted the expansive sweep of the preemption clause and concluded that a state law relates to a benefit plan if it has a connection with or reference to such a plan. See *id.* at 1047-48 (holding that because employee's claims "relate to" employee's benefit plan, such claims must fall under ERISA's preemption clause).

The type of recovery sought is based on negligence attributable to the delay occasioned by a cost containment protocol set by a for-profit organization, and which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries. . . . To find that such claims are preempted because they may interfere with what is in essence a business decision made in the financial interests of a commercial entity is inconsistent with the intention of ERISA and should not "suffice to trigger preemption."⁵⁰

Allowing ERISA to preclude tort suits against HMOs allows ERISA to serve as a shield for negligent practice and leaves the employee virtually defenseless.⁵¹ Leaving the worker without remedy allows the HMO to pursue its financial goals unchecked by any concern with accountability.⁵²

50. *Pappas v. Asbel*, 675 A.2d 711, 716 (Pa. Super. Ct. 1996) (citation omitted). In *Pappas*, the plaintiff, a subscriber to an HMO, complained to his doctor of neck and shoulder pain. *See id.* at 713. Despite treatment with steroids, the plaintiff's condition worsened significantly, and he complained of numbness throughout most of his body and became unable to walk. *See id.* The plaintiff was admitted to a local hospital where he was diagnosed with an epidural abscess that was compressing his spinal cord. *See id.* Plaintiff required immediate treatment at a hospital with more extensive facilities than those available at the local hospital. *See id.* Without immediate treatment, plaintiff's condition would worsen or become permanent. *See id.*

Plaintiff's doctors made numerous attempts to transfer the plaintiff to an approved facility. *See id.* Despite the pressing nature of the emergency, plaintiff's HMO significantly delayed approving plaintiff's removal to an authorized hospital. *See id.* After three hours of delays, plaintiff was transported to an authorized facility. *See id.* Plaintiff ultimately ended up with permanent quadriplegia. *See id.*

Plaintiff brought suit against his primary care physician for malpractice and against the local hospital, alleging that it was negligent in causing delay in transferring him to a suitable facility. *See id.* The hospital brought a third-party claim against the HMO, alleging that the HMO was negligent in refusing to authorize the transfer. *See id.* at 714. The HMO successfully filed a motion for summary judgment alleging that the third-party complaint should be dismissed because it was preempted by section 1144(a) of ERISA. *See id.* The Superior Court of Pennsylvania reversed the decision of the Court of Common Pleas and held that ERISA did not preempt the action because the negligence claim at issue had no connection to the benefit scheme that Congress sought to protect through ERISA. *See id.* at 717 (stating that there is "no connection to the benefit scheme which Congress sought to protect by preempting laws tending to produce conflicting systemic demands; ERISA is in no way implicated by the claim that [the HMO] negligently caused [plaintiff's] injuries by its delay in authorizing his transfer").

51. Remedies under ERISA are impractical and even more time consuming than tort suits. It is not coincidental that the HMOs argue for ERISA preemption.

52. In essence, ERISA can deny a cause of action for medical malpractice, leaving plaintiffs with no way of recovering for the acts of negligent parties. *See Coan, supra* note 48, at 1026 (explaining how "preemption effectively denies a malpractice action"). To further confound the issue, Congress has not replaced preempted state laws with substantive federal legislation. *See* Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 U. FLA. L. REV. 355, 436-40 (1994) (discussing why courts should cre-

C. *Immunity*

When HMOs were first being developed, some states wished to encourage them and for that reason gave them the shield of immunity from negligence suit.⁵³ Although this may have helped the trend toward cost cutting, a trend in which the state governments wished to participate, it left HMOs free to develop without the restraints that the threat of liability in tort would have brought with it. Although immunity might at one time have been justifiable, HMOs have arrived on the scene and no longer need immunity to protect them. They should be responsible for their acts.

The modern trend has been to eliminate immunities in favor of applying the same standards to all entities.⁵⁴ There is no reason why this trend should not include HMOs in those jurisdictions which granted immunity in the first place. HMOs, like other entities, should be held accountable for their decisions, and can purchase insurance to protect themselves when they are sued.

D. *Rationing*

Strictly speaking, rationing is not really a legal concept applicable (or not applicable) to HMOs. HMOs were a response to a perceived need to cut costs. Rationing is another such response. To a certain extent, HMOs serve as a rationing device, because they restrict access to services.⁵⁵ Rationing occurs when policy decisions are made to deny treatment in certain circumstances.⁵⁶ Rationing may be utilized to curtail the extent of

ate federal substantive law to provide relief for injured individuals who have been denied causes of action through ERISA).

53. See N.J. STAT. ANN. § 26:2J-25(c)-(d) (West 1996) (providing that authorized HMOs "shall not be deemed to be practicing medicine" and that "no person participating in the arrangements of [an HMO] other than the actual provider of health care . . . shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services"); see also *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58, 61 (Mo. 1989) (shielding HMO from liability in negligence action under Missouri statute that exempts health service organization from liability for injuries resulting from negligence).

54. For example, many states have elected to abolish charitable immunity. See, e.g., *Albritton v. Neighborhood Ctrs. Ass'n for Child Dev.*, 466 N.E.2d 867, 871 (Ohio 1984) (abolishing charitable immunity doctrine in Ohio and subjecting charitable organizations to liability in tort to same extent as individuals and corporations). One of the reasons for this action is that charities, like all other entities, should be responsible for their acts, and tort law is the primary means of enforcing this. See *id.* at 870 ("[A] personal injury is no less painful, disabling, costly, or damage producing simply because it was inflicted by a charitable institution rather than by any other party or entity").

55. Of course, if one can pay for the services denied by the HMO, one can receive them.

56. See FURROW ET AL., *supra* note 12, at 297 (distinguishing rationing from allocation). Professor Furrow states that

[t]hrough allocation decisions a society determines how much of its resources to devote to a particular purpose (for example, how much to allocate to Medicare, or to the End Stage Renal Dialysis Program, or to

services, for example at the end of life ("no respirators will be available to persons over the age of ninety"). Rationing may also be used to make decisions about substantive procedures, such as kidney transplants ("no transplants to persons over sixty-five").⁵⁷ If there were sufficient resources to pay for the maximum treatment for all members of society, rationing would not be necessary in the former situation. The latter situation represents a mixed decision to deny a scarce resource (an organ for transplant) to a group that "wastes" both the organ and the resources expended in the transplant process, in comparison to other possible recipients.⁵⁸ What makes the rationing decision to deny a kidney to a person over sixty-five years old a fair one is that the decision is not made about a particular individual, nor is a comparison between two individual recipients made. Rationing also occurs, however, when a decision is made as to which among a group of possible recipients should receive an organ.⁵⁹ As with age limits, consistency of criteria is vital in this context.

When consciously and deliberately done, a fair rationing system extends scarce resources to those who can most profit from their availability.⁶⁰ In the medical context, a fair rationing system requires that a

transplantation of hearts). Through rationing, a society decides who gets the resources allocated in a particular way; which individual gets the dialysis or the heart. Obviously, allocation decisions affect rationing decisions: the more resources allocated in a particular purpose, the fewer difficult rationing decisions need be made as to who gets the resources. Perhaps less obviously, rationing decisions affect allocation decisions; the more poignant rationing decisions become, the more likely is a society to allocate enough resources to avoid uncomfortable rationing decisions.

Id.

57. See GUIDO CALABRESI & PHILIP BOBBIT, *TRAGIC CHOICES* 186-89 (1978) (discussing procedures by which artificial kidneys and transplants have been allocated in United States); Arthur L. Caplan, *Organ Transplant: The Costs of Success*, HASTINGS CENTER REP., Dec. 1983, at 23-32 (same).

58. See Editorial, *Organ Shortage: Rationing Policy Assures New Livers for Patients Most Likely to Survive*, HARRISBURG PATRIOT & EVENING NEWS, Nov. 26, 1996, at A8 [hereinafter *Organ Shortage*] (discussing new rationing policy in which patients awaiting liver transplants who have best chance of surviving receive top priority).

59. See *id.* (discussing medical rationing in context of liver transplants). The determination as to which member of a group of possible recipients will receive a transplant is made through rationing:

The recent change in the policy used to determine which patients awaiting a liver transplant go to the top of the list has been described as "a case study of [medical] rationing."

Dr. Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, sees broader implications in the decision by the United Network for Organ Sharing to give priority in liver transplants to the sickest patients with the best prospect of surviving. He views it as a test case for medical rationing in general, "a canary in a mine that all of us will have to enter."

Id.

60. See CALABRESI & BOBBIT, *supra* note 57, at 31-50, 83-127 (discussing various allocation and rationing methods); FURROW ET AL., *supra* note 12, at 297-300 (same). Although rationing sounds straightforward, it is in fact extremely difficult to carry out in any visible manner. One reason why rationing on the basis of

decision as to who receives a particular service be made on a fair and uniformly applied set of criteria.⁶¹ Thus, the most appropriate (fair) rationing occurs when responsible decision makers, after scientific study, develop standards and rules that will insure that the resources reach their appropriate recipients.⁶² Unfair rationing occurs when no one is willing to make the hard decisions.⁶³ When this happens, resources are allocated unsystematically and by default, in a manner based on criteria that have nothing to do with sound medical practice and statistics. The primary default criterion is wealth.⁶⁴

Scarce resources remain scarce, whether explicit rationing decisions are made or not. When rationing decisions are not explicitly made, the market tends to determine the identity of recipients, and the scarce re-

wealth has continued to exist may well be that it is largely invisible, and not the product of public and openly made decisions.

When the individual who is denied a service becomes a real, live, visible being who is facing death, adherence to rationing may be impossible. See *id.* at 297-99 (arguing that society is more likely to expend vast amounts of resources to save lives of persons who are real and identifiable, and far less willing to spend such resources in saving lives of persons whom society does not see). There is also a distinction to be made between statistical and identifiable lives. In general, it is more likely that society will expend a huge amount of resources to save an identifiable life, while statistical lives will be sacrificed at a much lower cost. The distinctions between allocation and rationing and between identifiable and statistical lives are intertwined; allocation decisions usually affect statistical lives, while rationing affects identifiable lives. See *id.* at 297.

61. See *Organ Shortage*, *supra* note 58, at A8 ("The test for acceptable rationing is that it be, and be seen to be, fair and equitable."); see also CALABRESI & BOBBIT, *supra* note 57, at 187-88 (discussing inadequacies of rationing systems in which rationing decisions were made "mindlessly," without regard to fair and uniform criteria).

62. See Douglas J. Besharov & Jessica Dunsay Silver, *Rationing Access to Advanced Medical Techniques*, 8 J. LEGAL MED. 507, 520 (1987) (arguing that once it is concluded that rationing is necessary, reliance on medical criteria is most rational approach because patients for treatment are selected according to who can benefit most from such treatment). But see David Orentlicher, *Deconstructing Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 73 (1996) (arguing that random selection and lotteries should be used to ration health care). It has been argued that medical professionals should not be responsible for rationing decisions. See Orentlicher, *supra* note 23, at 166-67 (setting forth arguments as to why physicians should not engage in rationing decisions).

63. See CALABRESI & BOBBIT, *supra* note 57, at 186-91 (discussing how society dodges value-laden questions); FURROW ET AL., *supra* note 12, at 299 (stating that decision in United States to allocate sufficient resources for renal dialysis treatment was made to avoid any rationing decisions).

64. See Orentlicher, *supra* note 62, at 52 (noting that our society presently rations availability of health care based on wealth). Thirty-five of 52 state-administered acquired immune deficiency syndrome (AIDS) programs have had to make some kind of emergency move in the past year to curtail the expenditure of funds for new drugs. See Daniel Pedersen & Eric Larson, *Too Poor to Treat*, NEWSWEEK, July 28, 1997, at 60 (discussing curtailment of state AIDS programs because of inadequate funding). Of course, those with independent resources will be able to afford such drugs.

sources tend to go to those who can afford them.⁶⁵ In our society, such rationing should be viewed with repugnance. In the past, when such rationing has come to public attention, the response has been one of horrified shock.⁶⁶ For example, the federal government decided to pay for all kidney dialysis rather than have dialysis available only to those who could afford it.⁶⁷

Rationing on the basis of wealth has been allowed to proceed relatively unchecked, at least in part because no one has proved able to take on the task of explicitly rationing the resources at issue. It is also worth noting that those who have the greatest political power in our society are perfectly happy with a wealth-based system, because those with the greatest access to medical resources can only stand to lose when rationing based on other criteria comes into play.⁶⁸ HMOs, of course, are part of wealth-

65. See FURROW ET AL., *supra* note 12, at 298 (stating that unless market is used to allocate and ration resources, resources move only to those with wealth). The authors state that the problem with the market approach is that it can only move valued resources to members of society who already have resources. See *id.* Such allocations are inherently troubling, because they deny the equality of individuals.

66. See CALABRESI & BOBBIT, *supra* note 57, at 33 ("[W]hen tragic choices are made through the pure market within an existing distribution of wealth . . . it presents the wrenching spectacle of a rich man and a poor man bidding against each other for life."); Caplan, *supra* note 57, ("Historically, our society has been reluctant to withhold life-saving medical treatments on the basis of an inability to pay."); Lisa B. Deutch, *Medicaid Payment for Organ Transplants: The Extent of Mandated Coverage*, 30 COLUM. J.L. & SOC. PROBS. 185, 199-201 (1996) (noting that language of Medicaid act provides that medical treatment be given to poor persons); Maxwell J. Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WISC. L. REV. 239, 263-64 (1985) (stating that strong popular bias against allocating health resources on basis of wealth exists in part because "wealth is not even a crude measure of moral desert; the saintly are not likely to be rich, and philanthropists score high on virtue because of what they have given away not because of what they have kept"); Shana Alexander, *They Decide Who Lives, Who Dies*, LIFE, NOV. 15, 1962, at 124-25 (discussing society's shock in response to decisions made by committee composed primarily of lay persons who decided which persons would receive life-saving medical procedures and which persons would not).

67. See Mehlman, *supra* note 66, at 263-64 (discussing federal law which enable most patient with end-stage renal disease to have most of their hemodialysis treatment costs paid by Medicare). The decision that the federal government should fund all dialysis may be contrasted with the Medicare refusal to fund human immunodeficiency virus (HIV) treatment. See Pedersen & Larson, *supra* note 64, at 60 (reporting how lack of federal money prompted many states to cut off funding for AIDS treatment). The kidney dialysis decision was made in the era when decision makers thought that full funding of all needed medical treatment for all persons was possible. See Mehlman, *supra* note 66, at 248 n.42 (noting that kidney dialysis decision was made in 1972 and that this decision extended coverage of Social Security to persons under age 65 who had end stage renal disease). The HIV decision was made more recently. See Pedersen & Larson, *supra* note 64, at 60 (discussing how state governments in 1997 are struggling to find enough money to fund AIDS treatment programs).

68. See generally Orentlicher, *supra* note 62, at 73-75 (focusing on how society can ration health care in way that does not discriminate unfairly on basis of sickness). The author further points out that "[i]n the coming years, health care rationing will become increasingly common. Because of their substantial health care

based rationing, because those with the financial resources to pay for the freedom to choose doctors and procedures will continue to do so.

In the health care context in this country, the idea of rationing tends to appall the public.⁶⁹ Yet rationing exists; its existence follows from the fact that governments and insurers, including HMOs, have become unwilling to provide limitless medical care to those they insure.⁷⁰ If one is wealthy, limitless care remains accessible. If one is not, it does not.

V. THE CURE

The problem of HMO accountability has recently come to the attention of the states and courts, as well as to participants in HMO plans. In the absence of any threat of liability, HMOs, like any other entity, have put their own financial welfare first. They clearly face a conflict of interest between profit and patient, and it is not surprising that they have chosen profit. Nor can market pressures alone cure this problem. The employers who pay for their employees to be members of HMOs face the same economic pressures in that, as far as those paying the fees are concerned, the lower the fees, the better. Thus, those paying the fees have the same desire to keep costs down, even at the expense of the quality of care. In any event, market pressures have had the opportunity to fix the problem, and have not done so.

Other entities and individuals through the ages have faced similar conflicts. Some examples of these conflicts include the decisions facing surgeons, who will not collect a fee unless they recommend surgery, attorneys, who will not collect a fee unless they litigate, and stockbrokers, who will not make commissions unless they sell stock. These conflicts have been dealt with in various ways. The medical and legal professions have adopted codes of conduct that theoretically keep the exercise of professional judgment unbiased. The federal government keeps its eyes peeled for signs of churning by stockbrokers. Significantly, however, doctors and lawyers also run the risk of liability in tort for unnecessary surgery or legal malpractice. If members of these honored professions need the deterrent

needs and weak political power, persons with disabilities are at high risk of bearing more than their fair share of health care cost containment." *Id.* at 86.

69. See H. Gilbert Welch & Eric B. Larson, *Dealing With Limited Resources: The Oregon Decision to Curtail Funding for Organ Transplantation*, 319 NEW ENG. J. MED. 171, 172 (1988) (discussing public outcry in response to Oregon's policy to discontinue state funding for organ transplantation in order to extend its funding for basic health care to include 1500 persons not previously covered). For example, in Oregon in 1987, one child died from the inability to raise enough money for a bone marrow transplant. See *id.* The public response to the child's death was so strong that in 1990 the Oregon Legislature restored Medicaid funding for organ transplants, funding which it had previously cut as representing a poor allocation of limited financial resources. See FURROW ET AL., *supra* note 12, at 298 (noting that Oregon's legislature was "chastened" and restored Medicaid funding for transplants).

70. See, e.g., Pedersen & Larson, *supra* note 64, at 60 (discussing curtailment of state-administered AIDS treatment programs because of lack of sufficient funds).

effect that tort law provides to make sure that their own interests do not overwhelm the interests of their clients and patients, why should HMOs not need the same threat to keep their exercise of discretion reasonable? It may be the case that in the vast majority of situations doctors, lawyers and HMOs act conscientiously and reasonably. The deterrent effect of tort law is designed not for this majority, which does not need its incentive effect to act reasonably. For those who do, however, tort law provides an incentive for all potential defendants to act conscientiously and reasonably all the time.

It is clear that no individual or entity can operate entirely altruistically; rather, decision makers need the threat of some form of liability or sanction to keep their judgment pure. This fact has been recognized in the application of tort law generally; if society did not need it, it would not have been invented. Even charities, theoretically an embodiment of virtue and altruism, have lost their immunity. Removing the threat of tort liability gives any entity with a financial stake in the outcome the unbridled discretion to reach any decision it wishes. This cannot be justified by the history either of tort law or of humanity generally.

The problem of HMO discretion has clearly come to the attention of society. The responses to this problem have taken various piecemeal and ineffective forms. This Article now turns to these responses.

A. *Individual Appeals*

One way to approach the problem is for individual members of HMOs to challenge the HMO decision on a particular test or procedure. Participants in plans are asserting themselves, attempting to make the HMOs more responsive to their needs. This process of individual challenge within the HMO structure is both time consuming and ultimately unsatisfying, however, because it involves what may be critical delays and leaves the final decision in the hands of the party with the greatest incentive to deny the patient's requests. The patient has no weapons to use once the arguments within the HMO structure have been made.

B. *Statutes: HMOs in the Legislatures*

Another way to approach the problem is through legislative action.⁷¹ Legislative action, either taken or discussed, includes regulating the standards that the HMOs set for individual medical procedures (such as

71. The volume of legislative regulation aimed at HMOs has become enormous. Most of the regulations are aimed at key areas of consumer protection such as access to emergency care, access to specialists, quality of care, grievance procedures and HMO information disclosure. See *33 States Adopt HMO Bills with Consumer Protections*, WASH. HEALTH WK. J., July 29, 1996, at 1; see also Fred J. Hellinger, *The Expanding Scope of State Legislation*, 276 JAMA 1065, 1065-70 (1996) (tracing growth of three types of state laws that regulate managed care plans: direct access laws, laws that prohibit exclusivity clauses and laws that mandate minimum lengths of stays for deliveries).

preventing "drive-thru" deliveries and mastectomies and unduly restrictive emergency room standards),⁷² regulating HMO administration (such as preventing HMOs from creating financial incentives for nonreferral),⁷³ regulating HMO membership (such as prohibiting HMOs from rejecting

Much of the legislation being introduced is based on the AMA's Model Patient Protection Act, which first appeared in 1994. See Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489, 490-93 (1995) (claiming that HMOs have significantly reduced health care costs, but noting that many interest groups have promoted legislation that would heavily burden managed care plans by eliminating fundamental concepts upon which HMOs function).

In general, the legislation in question restricts managed care and gives more power to patients and physicians. Florida's version of a patient protection act is representative of proposals of this type across the country. See *id.* at 494-599 (discussing provisions of Florida's patient protection act). This act, which was not passed by the legislature, provides that managed care plans must provide prospective enrollees with detailed information on the plan's terms, conditions and contracts with its providers and seeks to increase physicians' ability to negotiate with HMOs. See *id.* at 493-94 (giving details of provisions).

Texas has been aggressive in regulating HMOs. See Bass, *supra* note 47, at T1 (describing proposed laws by Texas Legislature as "among the most pro-patient health-care rules in the country"). Proposals being considered or passed include opening HMOs to greater liability in malpractice suits and placing tighter restrictions on financial incentives given to physicians who work for a managed care plan and preventing many plans from signing exclusivity contracts with their doctors. See generally *id.*

The AMA has been an active force in promoting managed care regulation. See generally Steven Brostoff, *AMA Backing 'Anti-HMO' Legislation*, NAT'L UNDERWRITER—LIFE & HEALTH INS., May 30, 1994, at 1 (describing legislation regulating managed care that is backed by AMA); John Fairhall, *Clash of Titans: Doctors, HMOs, Insurers on Health Care*, BALTIMORE SUN, July 3, 1994, at E1 (discussing AMA's lobbying and advertising efforts to depict managed care as undermining medical decision making).

72. See, e.g., FLA. STAT. ANN. § 641.31(31)(a) (West 1995) (forbidding HMOs from limiting inpatient hospital care for mastectomies to period less than that determined by treating physician to be medically necessary); 215 ILL. COMP. STAT. 5/356t (West 1995 & Supp. 1997) (same); ME. REV. STAT. ANN. tit. 24-A, § 4237 (West 1995 & Supp. 1997) (same); N.M. STAT. ANN. § 59A-46-41.1 (Michie 1995) (requiring HMOs to provide at least 48 hours of inpatient care following mastectomy); OKLA. STAT. tit. 36, § 6060.5.B (West 1995 & Supp. 1997) (same); see also *States Move Multiple Health Care Bill in Fledgling Legislative Session*, HEALTH LEGIS. & REG., Mar. 26, 1997, at 2 (stating that two of top four issues nationwide are legislating mastectomy and maternity length of stay).

73. See, e.g., GA. CODE ANN. § 33-20A-6 (1995) ("A managed care plan may not use a financial incentive program that directly compensates a health care provider for . . . providing less than medically necessary and appropriate care to . . . patients."); MD. CODE ANN., INS. § 15-1008 (1997) (prohibiting HMOs from withholding payment based on services provided by physicians compensated on capitated basis); R.I. GEN. LAWS § 23-17.13-3(B)(8) (1995) (prohibiting health plans from entering agreements with physicians for payments that provide incentive to "reduce or limit services"); see also Tracy E. Miller, *Managed Care Regulation: In the Laboratory of the States*, 278 JAMA 1102, 1102-09 (1997) (discussing legislative efforts to restrict financial incentives that can be offered to physicians to deny medically appropriate or needed treatment).

physician applicants on what should be inappropriate grounds such as referral rates),⁷⁴ and regulating HMO rules (such as prohibiting "gag rules" that HMOs use to prevent physicians from disclosing the limitations of the care provided by the HMO).⁷⁵

74. See Miller, *supra* note 73, at 1104 (discussing AMA opposition to HMO plans that terminate physicians based on use of economic profiles, such as physician's referral patterns); Platt & Stream, *supra* note 71, at 490-93 (describing any willing provider statutes and similar prohibitions on restructuring membership); see also Susan R. Miller, *Black Doctors Say HMO Shut Them Out; Some Say the Issue Is Simple: The Color of Their Skin*, S. FLA. BUS. J. MIAMI, Apr. 4, 1997, at A1 (describing pending antidiscrimination legislation in Florida, in response to allegations of racial discrimination in hiring practices).

75. See, e.g., COLO. REV. STAT. ANN. § 10-16-121(1)(b) (West 1995) (prohibiting HMOs from terminating physicians for discussing treatment options, whether covered by plan or not, with patients); D.C. CODE ANN. § 35-4506(h)(1) (1996) (prohibiting HMOs from contracting with physicians to prevent physicians from discussing treatment options not covered by plan); IND. CODE ANN. § 27-8-11-4.5(a)(2) (1995) (prohibiting contracts between HMOs and physicians that disallow physicians from discussing treatment options not covered by plan); N.Y. PUB. HEALTH LAW § 4406-c2(b) (McKinney 1996) (same); VA. CODE ANN. § 38.2-3407.10J (Michie 1995) (prohibiting contracts between HMOs and physicians that forbid discussion of medical treatment options).

Antigag rule policies were adopted by 18 states in 1995 and 1996. See Miller, *supra* note 73, at 1105. Another 18 states instituted such policies between January and August 1997. See *id.* (noting that "18 states followed suit"). As of December 31, 1996, 13 states had adopted antigag rule policies with respect to contracts between physicians and HMOs that prohibit disclosure of plan limitations, including California, Colorado, Delaware, Indiana, Maine, Maryland, Massachusetts, New Hampshire, New York, Oklahoma, Rhode Island, Vermont, Washington and the District of Columbia. See *id.*

Pending legislation in New York and New Jersey would provide some of the most consumer-oriented protections in the United States. See Hellinger, *supra* note 71, at 1068 (describing new legislation emerging in wake of public pressure, especially in light of high-profile death in New Jersey). A New York consumer protection bill purports to balance the concerns of patients with those of employers, HMOs and insurers. See *N.Y. Consumer Protection Bill Bans Gag Clauses, Mandates Disclosure*, WASH. HEALTH WK. J., July 29, 1996, at 2 (describing New York bill that addresses gag clauses, provider payment incentives, specialty care access and emergency room coverage).

A New Jersey health care quality act would prohibit gag clauses in physician contracts, prevent HMOs from penalizing doctors for providing necessary care to patients, require HMOs to offer patients the option of going out of network to seek medical care, allow an external treatment decision appeals panel to fine an HMO up to \$10,000 for engaging in a pattern of denying necessary medical care, prohibit HMOs from ending a doctor's contract because he or she prescribed too much care and give doctors the authority to determine what is medically necessary. See *Statelines New Jersey: Senate Approves Health Care Quality Act*, AM. POL. NETWORK, May 23, 1997, at 9.

The federal government has also been active in regulating HMOs. See Spencer Rich, *Managed Care, Once an Elixir, Goes Under the Legislative Knife; Cost-Cutting Focus Feared Harmful to Patients*, WASH. POST, Sept. 25, 1996, at A1 (noting that AMA has been pushing for federal standards). Lawmakers in Washington and in state capitals are rethinking HMO cost-cutting emphasis. See *id.* (stating that legislative initiatives have been pushed nationwide because of concern that managed care has jeopardized patient health). For example, Congress approved legislation requiring insurance companies to pay for at least 48-hour hospital stays for mothers giv-

The legislative actions in this arena are aimed largely at individual problems that have come to the attention of the state government through public outcry.⁷⁶ Examples of this include legislation to allow women to remain in the hospital for 48 hours after childbirth⁷⁷ and legislation re-

ing birth, and a bipartisan bill being considered in Congress would bar HMOs from imposing gag rules that prevent physicians from fully informing patients about what their medical options are and which of those options the plan will pay for. *See id.* Several other bills pending in Congress address issues such as quality of emergency hospital care provided by medical plans. *See id.*; *see also* Diane M. Gianneli, *Congress Considers Ban on Managed Care "Gag" Clauses*, AM. MED. NEWS, June 17, 1996, at 3 (discussing former AMA President Robert McAfee's testimony before House Commerce Health Subcommittee stating that gag clauses "violate sound public policy and should be made unenforceable and legally null and void").

76. *See 33 States Adopt HMO Bills with Consumer Protections*, *supra* note 71, at 1 (noting that during first six months of 1996, 33 states enacted consumer protection laws related to managed care and at least 1000 more were introduced); *State by State Look at HMO Regulations*, GANNETTE NEWS SERV., July 23, 1996, *available in* 1996 WL 4381809 (listing, on state by state basis, various legislative reforms that each state has enacted); *see also* Robert Pear, *A Prescription for Communication: Sixteen States Pass Laws to Prevent HMOs from Restricting What Doctors Tell Patients*, ROCKY MOUNTAIN NEWS, Sept. 22, 1996, at 2B (discussing growing concern regarding efforts by HMOs to limit what doctors can tell their patients).

Legislative initiatives attempting to regulate the managed care industry are a response to concerns that cost-cutting measures by managed care organizations are dangerous. *See* Steve Sakson, *Out Front: Highly Criticized, HMOs Face Wave of Restrictive Legislation*, ASSOCIATED PRESS, Mar. 14, 1996, (stating that tales of shabby hospital care and doctors opting for cheapest treatment, rather than most appropriate treatment, have spawned backlash legislation in at least 40 states); *see also* David S. Hilzenrath, *Backlash Builds Over Managed Care; Frustrated Consumers Push for Tougher Laws*, WASH. POST, June 30, 1997, at A1 (discussing backlash against managed care and resulting legislation).

For example, in Missouri, the governor signed a bill requiring managed care companies to pay for emergency room visits whenever a "prudent layperson" would have reason to believe that immediate care is needed, even if the managed care administrator does not agree. *See id.* The Connecticut Legislature approved a bill that would allow patients to appeal to the state insurance commissioner when health plans decide not to pay for their medical treatment, and Texas has removed a barrier that had formerly prevented consumers from suing HMOs for medical malpractice. *See id.* A budget bill passed by the House of Representatives would require Medicare HMOs to defer to doctors on key decisions about coverage, and nine states have ordered coverage of hospital stays for mastectomies. *See id.* (listing states). At least 23 states require that HMOs allow women some measure of guaranteed access to obstetrics and gynecology (OB/GYN) care instead of leaving the decision to gatekeeper physicians. *See id.* New York has ordered HMOs to allow specialists to serve as primary doctors for patients with life-threatening, degenerative or disabling conditions, and 16 states have enacted requirements involving coverage of emergency services, many similar to Missouri's "prudent layperson" rule. *See id.* The District of Columbia and 34 states have outlawed gag clauses. *See id.* At the federal level, the movement to increase regulation of managed care is gathering momentum as typified by a number of bills that would impose new requirements in federal health insurance programs, including a version of the "prudent layperson" rule for emergency services. *See id.*

77. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-2912.01 (West 1995) (preventing health care group contracts from restricting benefits for child birth hospital stays to less than 48 hours following normal delivery); KAN. STAT. ANN. § 40-2,160(a)(2)(b) (1996) (requiring all health plans to provide coverage for at least

quiring that an HMO pay for emergency room visits whenever a "prudent lay person" would have gone to an emergency room.⁷⁸ Some of the statutes restore a reasonableness standard with respect to the specific situations with which they deal.⁷⁹ Some set specific standards, no more flexible than those the HMO would have set, albeit more generous to the patient.⁸⁰ Some states have elected to regulate HMOs in an effort to prevent their profit motive from affecting their judgment. These statutes include laws forbidding HMOs from penalizing gatekeeper doctors for referring their patients to specialists or for testing and laws forbidding the creation of incentives to accomplish the same result.

Individual laws directed at individual procedures and forms of HMO conduct are highly inefficient as a solution to the problem posed.⁸¹ The problem is a general one of HMO focus, not one with policies on delivering babies or preventing patients from finding out that a better, more expensive treatment might give them a better chance at a cure. There are close to an infinite number of treatments and protocols, and legislatures cannot deal with them individually. Indeed, to think that legislatures should proceed through the panoply of medical procedures, enacting a

48 hours of inpatient care following child birth); MASS GEN. LAWS ANN. ch. 176G, § 41 (West 1996) (same); N.J. STAT. ANN. § 17B:27A-7.1a (West 1996) (same).

78. See, e.g., ARK. CODE ANN. § 20-9-309(c)(1) (Michie Supp. 1995) (defining emergency services with respect to a "prudent lay person"); GA. CODE ANN. § 33-20A-3(2) (1981) (same); MD. CODE ANN., HEALTH-GEN. II § 19-701(d) (1996) (same); VA. CODE ANN. § 38.2-4300 (Michie 1996).

79. For a discussion of the "prudent lay person" standard and standards legislated by other states, see Diane E. Hoffmann, *Emergency Care and Managed Care—A Dangerous Combination*, 72 WASH. L. REV. 315, 368-73 (1997).

80. See Hilzenrath, *supra* note 76, at A1 (stating that Missouri law requires HMO coverage of emergency charges under "prudent layperson" standard); Rich, *supra* note 75, at A1 (discussing legislation that requires 48-hour stay for mothers giving birth); Andy Miller, *Bills Regulating HMOs on Tap for Legislature: Backers Say Patients Deserve More Information*, ATLANTA J., Jan. 9, 1997, at E01 (describing new federal rule that would prohibit financial incentives for cost cutting); see also Laura H. Harshbarger, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 217 (1996) (describing danger that "Congress likely never considered managed care issues at all" in enacting ERISA); Debra E. Kuper, *Newborn's and Mother's Health Protection Act: Putting the Brakes on Drive-Through Deliveries*, 80 MARQ. L. REV. 657, 680 (1997) ("[D]ispensing medical advice is out of bounds for a . . . legislature."). See generally Richard Frank, *Regulatory Responses to Information Deficiencies in the Market for Member Health Services*, in THE FUTURE OF MEMBER HEALTH SERVICES RESEARCH 113 (1989) ("[S]everal state legislatures have extended mandates on mental health benefits to HMOs.").

81. See Miller, *supra* note 73, at 1102 (discussing ineffectiveness of legislation directed at individual procedures, such as granting right to inpatient care following mastectomy or child birth). One commentator suggests that

[l]ike state legislation granting the right to inpatient care following mastectomy, the maternity stay laws suggest a treatment-by-treatment approach that is clinically specific and inherently limited in impact. Although less publicized, regulatory initiatives in many states have been designed more broadly to promote . . . patient rights . . .

Id.

statute about each one, is ridiculous. Not only are there too many to confront, but the standards of care change. A statute might require a four-day stay for the removal of a gallbladder, for example. With the invention of laparoscopic surgery for gallbladders, such removal has become an overnight procedure. Or a statute might require that a patient receive an X ray in certain circumstances and itself require that the hospital act negligently, because more sophisticated machinery has become available. Would the legislature amend its statutes every time medical practice changes?

Statutes directed at individual procedures are also unsatisfactory because they only deal with those few procedures that happen to provoke public outrage, although there are many more that should do so, but that never enter the public eye. The fact that a particular HMO standard has received public attention should not be the sole factor in the medical decision-making process.

Moreover, if the primary evil of HMOs involves medical decision making by nonmedical or nontreating personnel, legislation oriented towards specific procedures suffers from the same infirmity. Surely doctors should be making the decisions, not the HMO or the legislature. Individual laws replace medical judgment with legislative judgment, surely not a result that will ultimately help anyone.

If there is a simple solution to this problem that would eliminate the need for all this legislative activity, that solution should be adopted. If there are two ways to accomplish a goal, one of which is simple, flexible and straightforward, and the other of which is complex, inappropriate and convoluted, the simple solution is bound to be more effective.

Many of the laws mentioned above have been enacted in an effort to allow the physician's best medical judgment to prevail over the HMO's desire to cut costs. There is a much easier way to reach this result, however. Holding HMOs liable for negligence when they attempt to foreclose the doctor from exercising his or her judgment accomplishes precisely the same goal, without all the legislative activity.⁸²

82. There are those who might argue that holding HMOs to a reasonableness standard would release a flood of litigation. One response to this assertion is that there already is a flood, of both litigation and legislative activity. In any event, litigation directed against managed care organizations is already on the rise. See Louise Kertesz, *Data Signal Managed Care Suits on the Rise*, MOD. HEALTHCARE, May 20, 1996, at 17 ("Five years' worth of claims data from Farmers Insurance Group support the belief of some healthcare attorneys that claims and lawsuits alleging negligence under managed care are growing."). Patients are increasingly willing to challenge HMOs in court. See Edward Felsenthal, *When HMOs Say No to Coverage, More Patients Are Taking Them to Court*, WALL ST. J., May 17, 1996, at B1 (stating that more people are suing HMOs when they receive what they consider inadequate care and that "some patients are going straight to a lawyer as soon as coverage for routine care is denied").

C. *The Piecemeal Common Law Approach*

In the absence of a uniform negligence standard, courts have struggled to use the common law to reach appropriate results in individual cases.⁸³ The doctrine of respondeat superior, pursuant to which the employer is liable for an employee's negligence, has supplied a basis for liability, but has not always been successful in the face of arguments by the HMOs that the doctors, and not the HMO, made the challenged decisions.⁸⁴ Respondeat superior doctrine, moreover, holds the HMO liable

83. HMOs are being exposed to litigation under various theories of liability including vicarious liability (respondeat superior and ostensible agency), direct corporate liability (negligent selection/supervision and utilization management), breach of warranty, breach of contract, misrepresentation/false advertising and bad faith. There has also been a substantial amount of litigation revolving around ERISA preemption. See Bearden & Maedgen, *supra* note 48, at 337-46 (discussing various theories of liability); Helene L. Parise, Comment, *The Proper Extension of Tort Liability Principles in the Managed Care Industry*, 64 TEMP. L. REV. 977, 996-98 (1991) (discussing various forms of derivative theories of liability, including respondeat superior).

84. Under respondeat superior, the HMO is liable for the negligence of its employees, the doctors. See Bearden & Maedgen, *supra* note 48, at 300 ("In order for an HMO to be vicariously liable under the doctrine of respondeat superior, an employer-employee relationship or a closely analogous relationship between the HMO and the physician must be found.").

Case law regarding HMOs and the doctrine of respondeat superior indicates that the relationship of the HMO to the physician is indeed a critical factor. See *Fredman v. Kaiser Found. Health Plan of Colo.*, 849 P.2d 811, 816 (Colo. Ct. App. 1992) (holding that patients could not proceed under respondeat superior because HMO was statutorily precluded from directing or controlling independent contractors); *Raglin v. HMO Ill., Inc.*, 595 N.E.2d 153, 156 (Ill. App. Ct. 1992) (finding HMO not liable under respondeat superior for actions of independent contractors); *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987) (finding nature of employer-employee relationship critical in establishing liability under doctrine of respondeat superior); *Chase v. Independent Practice Ass'n*, 583 N.E.2d 251, 254 (Mass. App. Ct. 1991) (stating that test of vicarious liability for physician negligence is control or right of control by HMO); *Williams v. Good Health Plus, Inc.*, 743 S.W.2d 373, 379 (Tex. Ct. App. 1987) (finding HMO not liable for faulty prescription under theories of respondeat superior or ostensible agency). The case law sometimes also reflects a failure to take into account the control that the HMO may in fact be exercising over the doctors in the plan.

In one case, an HMO was found vicariously liable for the negligence of its consulting physician, despite an HMO argument that the physician was an independent contractor. See *Schleier v. Kaiser Foundation Health Plan of the Mid-Atlantic States*, 876 F.2d 174, 177-78 (D.C. Cir. 1989). The court held that the HMO had some ability to control the behavior of the consulting physician because the physician answered to the patient's primary care-taker, an HMO doctor, and it appeared that the physician's actions in performing the health care fell within the HMO's regular business. See *id.*

Similarly, in *Sloan v. Metropolitan Health Council*, the appellate court reversed the finding of the trial court and found the HMO liable under the theory of respondeat superior for the negligent acts of a member physician. *Sloan*, 516 N.E.2d at 1109 ("We see no reason why [an HMO] should be exempt from the doctrine of respondeat superior while professional corporations are not."). The appellate court pointed out that the physician providing treatment was engaged by the

only for physician negligence, and does not allow a direct challenge to HMO conduct. To serve the goal of insuring appropriate HMO conduct, respondeat superior doctrine in this context would require the conclusion that doctors who obey their HMO's strictures against their own better judgment may be negligent for doing so. A much more direct way to accomplish this result—and one that does less damage to the physicians who, by hypothesis, are not really at fault—would be to allow suits directly based upon HMO decision making.

Another theory of liability closely related to respondeat superior is that of ostensible agency.⁸⁵ Under ostensible agency, an HMO is liable for physician negligence when the patient reasonably believes that the physician is the agent of the HMO.⁸⁶ This theory suffers from the same infirmi-

HMO under a written employment contract and that an employment relationship thus existed. *See id.*

Finally, in a New Jersey case, the court determined that an HMO can be held liable under the doctrine of respondeat superior. *See Dunn v. Praiss*, 606 A.2d 862, 869 (N.J. Super. Ct. App. Div. 1992) (stating that physician was direct employee of HMO because he performed services at HMO offices for payment based on HMO subscribers, and thus, HMO may be liable under doctrine of respondeat superior), *rev'd on other grounds*, 656 A.2d 413 (N.J. 1995). The court also found that the HMO could be held liable under an agency theory. *See id.* at 868 (finding that physician was not acting as independent contractor for HMO, but rather as agent of HMO). Because of the control that the HMO was able to exercise under this relationship, the physician was found to be an ostensible agent of the HMO. *See id.* at 868 n.4 (listing factors showing control exercised by HMO, such as physician's inability to accept or reject particular patients and referrals solely at HMO's option).

85. Ostensible agency is defined in the *Restatement (Second) of Agency* as: One who represents that another is his [or her] servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he [or her] were such.

RESTATEMENT (SECOND) OF AGENCY § 267 (1957); *see* Bearden & Maedgen, *supra* note 48, at 309 (defining ostensible agency theory in context of vicarious liability).

86. *See* Bearden & Maedgen, *supra* note 48, at 310 ("If the patient justifiably relies on the skill of the physician in the belief that an agency exists, the HMO may be vicariously liable as if actual agency existed."). Under ostensible agency, an HMO can be held liable for physician negligence when appearances have led a patient reasonably to believe that a physician or health care provider was in the employ of the HMO. *See* Earlene P. Weiner, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 564 (1990) ("[P]laintiffs must prove reliance on the HMO's misrepresentation of its independent contractor-physicians as employees."); *see also* Karsten v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 808 F. Supp. 1253, 1258 (E.D. Va. 1992) (holding HMO liable as tortfeasor in member's action against HMO for negligent care and treatment); *Elsesser v. Hospital of Phila. College of Osteopathic Med.*, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (holding that HMO may be liable for negligence of independent contractor if provider is ostensible agent).

In one case, the court reversed a grant of summary judgement for an HMO under what appears to be a combination of ostensible agency theory and direct liability for negligence. *See Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (stating that issue of material fact existed as to whether participating physicians were ostensible agents of HMO). In *Boyd*, the court ruled that

ties as respondeat superior generally. Unless a doctor who disobeys HMO directions is negligent, ostensible agency cannot get at the source of the problem.⁸⁷

In response to the perceived inadequacies of respondeat superior and ostensible agency liability as applied to hospitals, courts developed the theory of corporate liability.⁸⁸ Under this doctrine, hospitals could be held liable for failing to make sure that the doctors practicing within their walls were competent.⁸⁹ Under this theory, HMOs have a direct duty to supply adequate health care to their patients.⁹⁰ This source of obligation has met with mixed success in the courts, particularly because the HMO may have

the HMO could be negligent in failing to oversee physicians and hospitals that appeared and acted as agents of the HMO. *Id.* at 1234-35. Similarly, in another case, an HMO was found vicariously liable under the ostensible agency doctrine for representing that its primary care physicians were carefully screened and fully qualified. *See McClellan v. Health Maintenance Org.*, 604 A.2d 1053, 1058 (Pa. Super. Ct. 1992) (finding that primary care physician was held out as agent of HMO). This representation was inaccurate. *See id.* As in *Boyd*, this ruling appears to be a mixture of vicarious and direct liability.

Conversely, in *Raglin v. HMO Illinois, Inc.*, the court rejected the theory of ostensible agency because quality assessment and utilization review guidelines were not the type of control that implies that an agency relationship exists. *Raglin*, 595 N.E.2d at 158 (finding HMO's administrative role in overseeing health care delivery, rather than addressing accuracy of medical diagnoses or opinions and determining appropriateness of medical services delivered, did not constitute control necessary to impute agency relationship). Similarly, in *Chase*, the court ruled that the HMO did not control the activities of the negligent physician and that the plaintiff had failed to show any reliance that would make the doctrine of ostensible agency applicable. *Chase*, 583 N.E.2d at 254-55.

87. *See Weiner, supra* note 86, at 546 (explaining that doctrine of ostensible agency holds HMOs liable when HMOs create appearance that agency relationship exists between HMO and negligent physician); *see also* James B. Cohoon, Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 383 ("According to the doctrine of corporate hospital liability, hospitals may be held liable for the negligent conduct of their . . . autonomous staff physicians." (emphasis added)).

88. Under a theory of corporate liability, liability does not depend upon a particular relationship between an entity, such as a hospital or HMO, and the physician. *See Alan D. Allred & Terry D. Tottenham, Liability and Indemnity Issues for Integrated Delivery Systems*, 40 ST. LOUIS U. L.J. 457, 458 (1996). Rather, this liability arises "from a hospital's responsibility to the general public to meet a standard of care." *Id.*

89. *See Bearden & Maedgen, supra* note 48, at 321 (stating that "doctrine is based on belief that hospitals should play a greater role in controlling the quality of care provided to patients by determining that their medical staff members are qualified and competent"). Corporate liability imposes a duty on hospitals to select and retain only competent physicians, oversee patient care administered by all physicians practicing in the hospital and develop adequate rules and policies to ensure quality care for patients. *See Allred & Tottenham, supra* note 88, at 458 (citing *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991)).

90. *See Allred & Tottenham, supra* note 88, at 458. Although the doctrine was originally applied to hospitals, courts have since extended its scope to include HMOs. *See id.* (stating that liability based on corporate negligence, such as negligence in selecting and screening of staff, has been extended to managed care organizations).

some kind of immunity from suit.⁹¹ Moreover, this theory cannot reliably supply a basis for liability when the challenge is not to the quality of the doctor, but rather to the quality of the HMO.⁹² Corporate negligence doctrine requires an underlying act of negligent medical practice to trigger hospital liability. When the HMO policy has been followed by the physician, that physician has not been negligent (unless, of course, adhering to HMO policy is declared to be negligent).

Breach of contract or warranty theories sometimes appear in response to HMO conduct,⁹³ as do claims that the HMO has engaged in fraudulent

In *McClellan*, the court ruled that HMOs have a nondelegable duty to select and retain competent primary care physicians. See *McClellan*, 604 A.2d at 1059 (finding HMO duty to select and retain only competent primary care physicians arising out of action under section 323 of *Restatement (Second) of Torts*). The *McClellan* court relied heavily on section 323 of the *Restatement (Second) of Torts*, which provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of harm, or (b) the harm is suffered because of the other's reliance upon the undertaking.

RESTATEMENT (SECOND) OF TORTS § 323 (1965).

Direct corporate liability can also exist in the arena of utilization review and management. See generally *Allred & Tottenham*, *supra* note 88, at 462 (“[A] managed care entity performing utilization review could be liable for complications suffered by the patient.”). Utilization review is a cost containment and quality insurance strategy utilized to promote cost control efforts and efficiency. See Cheryl E. Schessler, Comment, *Liability Implications of Utilization Review as a Cost Containment Mechanism*, 8 J. CONTEMP. HEALTH L. & POL’Y 379, 380 (1992).

The seminal case in this area is *Wickline v. California*, 228 Cal. Rptr. 661 (Ct. App.), *vacated*, 727 P.2d 753 (Cal. 1986). In *Wickline*, although the court did not hold the third-party payor liable, it did forecast the potential for liability of parties involved in cost containment and utilization review programs. See *id.* at 670. Specifically, the court held that payors could be held liable when a questionable medical decision results from “defects in the design or implementation of cost containment mechanisms.” *Id.*

91. For example, in one case, the court refused to discuss the merits of a claim under direct corporate liability for the negligent selection of a surgical specialist. See *Harrell v. Total Health Care*, 781 S.W.2d 58, 59-60 (Mo. 1989). Instead, the Missouri Supreme Court held that a Missouri state statute granted immunity to HMOs for this type of liability. See *id.* at 60.

92. See, e.g., *Jass v. Health Care Plan, Inc.*, 88 F.3d 1482, 1488-89 (7th Cir. 1996) (dismissing claim against ERISA plan administrator for breach of duty to manage, control and determine medical care).

93. See *American Health Care Providers, Inc. v. O'Brien*, 886 S.W.2d 588, 591 (Ark. 1994) (holding that insured failed to establish that HMO breached contract by not paying bills); *Hughley v. Rocky Mountain Health Maintenance Org., Inc.*, 910 P.2d 30, 34 (Colo. Ct. App. 1995) (stating that insured's tort claims against HMO were subject to arbitration provision of contract when based on HMO's denial of benefits); *Pasteur Health Plan, Inc. v. Salazar*, 658 So.2d 543, 544 (Fla. Dist. Ct. 1995) (holding that HMO insurance plan is contract of adhesion); *Dunn v. Praiss*, 656 A.2d 413, 421 (N.J. 1995) (holding that physician who was found liable for malpractice could not assert claim for contribution against HMO based on

conduct.⁹⁴ An HMO would hardly want to argue, however, that fraud and bad faith doctrines should take on the role that negligence theory was designed to play. This would lead inevitably to a drastic expansion of what the courts would consider to be fraud or bad faith and increased exposure to punitive damages.

D. *The Scalpel*

The various statutory and common law responses to the problem of HMO discretion share a common thread. They all seek to focus HMO attention on the patient, not on the HMO's bottom line. They are all underinclusive, in that they apply to certain isolated manifestations of the problem. They all exist in response to what has proven to be the mistake of exempting HMOs from the normal operation of negligence principles. The simplest answer must be elimination of the exemption. The usual rule of accountability was altered for HMOs as an experiment. The very volume of activity in this area proves that the experiment has failed. This failure has been recognized in the staggering amount of legislative and judicial effort expended in an effort to insure HMO responsibility. That effort, however, has been oriented toward smoothing the individual bumps in the carpet of accountability, one at a time. Surely it would be more effective and efficient to smooth out the entire carpet, all at once.

breach of contract because plaintiff's claim against HMO was based on theory of respondeat superior or agency).

As a profit-driven entity, HMOs employ aggressive marketing tactics to obtain new subscribers and keep existing subscribers. See Bearden & Maedgen, *supra* note 48, at 330 (explaining breach of warranty theory as applied to HMOs). "Statements in the subscriber contract[s] or in promotional materials may [expose] the HMO to claims that the HMO breached its warranty to the . . . subscriber." *Id.* (quoting David J. Oakley & Eileen M. Kelly, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 634 (1988)).

In one case, the court held that a party can be liable under a breach of warranty theory when the party in question has "clearly and unequivocally warranted that a course of treatment recommended . . . will, inevitably, produce a certain result." *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392, 393 (Ct. App. 1979). The court did not find liability because the language upon which the plaintiff relied simply claimed that the physician would exercise good judgment. See *id.* (ruling that HMO was not liable under breach of warranty theory because treating physician did no more than make a "generalized promise of a good result").

94. See Bearden & Maedgen, *supra* note 48, at 344-45 (explaining context in which bad faith may be asserted in connection with HMO administration). There are many activities conducted by HMOs that may lead a plaintiff to pursue a cause of action for bad faith or fraud. See Joanne B. Stern, *Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, 85 W. VA. L. REV. 911, 920 (1983) (describing context in which potential bad faith claims against HMOs may arise). These include refusal to approve a referral of the patient to a specialist or to approve admission for hospital inpatient services, failure to approve diagnostic tests because of the expense involved, refusal to approve life support for a patient who has only a slight chance of survival, provision of misleading or deceptive information about benefits and coverage either to reduce utilization or induce enrollment, making administrative errors in enrollment, and refusal to cover experimental procedures or to approve extensions of hospital stays. See *id.* at 921-22.

This author does not advocate doing away with the carpet entirely—just fixing it so that it lies smoothly and ceases to trip those who seek to cross it. The reinstatement of a negligence standard and the recognition that HMOs that overrule individual medical judgment are acting unreasonably would accomplish this.

The best way to focus attention on the patient's interest is, quite simply, to hold the HMO responsible for the decisions it makes. A system exists for doing just this: the tort system. An HMO that overrules its physician's judgment would be acting unreasonably in doing so for several reasons, all of which are firmly embedded in the law already. These already embedded legal doctrines include prohibitions against practicing medicine without a medical degree and a license and the inclusion of negligent medical practice among the torts. Nor could the HMO employ a reasonable HMO standard and argue that other HMOs would have acted similarly. No matter what other HMOs would do, it would be unreasonable to overrule the physician's exercise of reasonable medical judgment. HMO practice would not be a defense if the HMO standard of conduct is itself negligent.⁹⁵ Overruling the reasonable exercise of medical judgment is itself negligence.

The HMO personnel who intervene between the physician and the patient to prevent the doctor's judgment from being effectuated have not themselves met with or treated the patient. Thus, HMO personnel who prevent the physician's judgment from being exercised are acting irresponsibly in treating a patient from a distance. The process of overruling the physician's judgment means that the HMO personnel are, in fact, practicing medicine. If they are not doctors, they are acting illegally in practicing medicine without a license, and should be accountable for doing so. Moreover, presumably the HMO has hired the doctor to allow the doctor to exercise his or her trained judgment.⁹⁶ Unless the HMO personnel are doctors, they are not allowed to practice medicine. If they are doctors, presumably they are acting in a way unacceptable to the medical profession in making decisions based solely on statistics and without seeing the patient.

An HMO governed by a negligence standard would not be able to overrule the medical judgment of the physician in his or her reasonable decision to recommend treatment or tests. Of course, HMOs developed, in part, in response to the belief that doctors had gone overboard in ordering excessive treatments or tests and that the medical system had, as a whole, been taken into the arena of excessive spending. HMOs developed to cut costs that were perceived as having run amok. There are those who would argue that returning complete discretion to physicians would

95. See *Low v. Park Price, Co.*, 503 P.2d 291, 297 (Idaho 1972) (holding that industry practice was not conclusive evidence of reasonable care).

96. If this is not the case, then HMOs should contend that they do not need to employ doctors at all. They would only need administrative personnel to apply the uniform treatment protocols followed by the HMO.

amount to a return to the excessive spending that HMOs were designed to cure. The response to this position has two parts. First, HMOs have failed in their mission to provide less expensive medical care in an equitable manner. Medical care remains rationed on the basis of wealth. Given the choice between a return to allegedly excessive medical costs and allowing HMOs to deepen the divisions between the economic levels in our society, this author would elect the former.

Second, a balance among all concerns must be possible. Perhaps medical spending needs to be curtailed. Experience is starting to show that the HMO approach of uniform standards applied without flexibility cannot work; that approach provides too little room for individual variation and needs. HMOs, with the requirement of reasonableness removed or sporadically reinstituted, have failed to balance the perceived need to cut medical costs, the interests of their patients and the policy concerns about providing medical care fairly. They had their chance, and the amount of micromanaging they have generated from legislatures and courts proves their failure.

The balance among all concerns can be struck by a return to a reasonableness standard. HMOs can operate by attempting to weed out those referrals, procedures and tests that are unnecessary. Because it is hard to believe that anyone would openly argue that HMOs exist to curtail necessary procedures, any supervision on their parts should be restricted to curtailing unnecessary ones. Presumably, the idea that medical costs have become excessive applies only to unnecessary medical costs. Arguing that necessary medical costs are excessive becomes problematic, because it must lead to open acceptance of the view that there comes a point beyond which society would rather have a patient die than pay for the care that the patient needs.⁹⁷ Thus, allowing HMOs to act as supervisors to make sure that no unnecessary treatments are supplied to their members would serve the goal of eliminating unnecessary costs. An HMO acting in such a way would be acting reasonably, and the HMO would not be liable if sued for negligence. The HMO's discretion, however, must be fettered by the requirement of reasonableness. This fetter has been ably supplied through the centuries by tort law. Removing it has led to problems, as this Article has shown. Existing attempts to refetter HMOs have proven inefficient, ineffective and underinclusive. We should return to a reasonableness standard and end the experiment with immunity in one straightforward step. It is the simplest solution.

97. This view does exist, and has clearly been put into practice in decisions by Medicare, for example, not to pay for the drugs that an HIV patient needs. See Pedersen & Larson, *supra* note 64, at 50 (discussing whether death is cheaper than 13-year treatment with drugs that an HIV-positive patient needs). The issue, however, has not been openly faced.

